GOVERNMENT OF THE DISTRICT OF COLUMBIA

PUBLIC EMPLOYEE RELATIONS BOARD

In the Matter of:	:	
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, LOCAL 383, AFL-CIO	:	
Complainant,	:	PERB Case No. 02-U- April 23, 2002
and	:	
DISTRICT OF COLUMBIA DEPARTMENT OF. MENTAL HEALTH	:	
Respondent.	:	

RESPONDENT'S ANSWER AND AFFIRMATIVE DEFENSES TO UNFAIR LABOR PRACTICE COMPLAINT

Respondent, District of Columbia Department of Mental Health, by and through representative, pursuant to the Public Employee Relations Board Rules and Regulations 520.6, hereby submits its answer and affirmative defenses to the Unfair Labor Practice Complaint filed by Complainant American Federation of Government Employees Local 383. Respondent respectfully requests that PERB deny and/or dismiss Complainant's Unfair Labor Practice Complaint and states the following:

[1] The Union holds a joint certification as the exclusive collective bargaining representative of mental health services bargaining unit employee at CSA.

ANSWER: Respondent neither admits nor denies the averments. The information is solely within the knowledge of the Complainant, an adverse party, and therefore no response is required.

[2] CSA is an agency of the District and is subject to the jurisdiction of the Public Employee Relations Board in accordance with D.C. Code section 1-602.1.

ANSWER: Respondent denies that the CSA is an agency of the District and is subject to the jurisdiction of the Public Employee Relations Board in accordance with D.C. Code section 1-602.1. The CSA is an operational entity of the District of Columbia Department of Mental Health. The District of Columbia Department of Mental Health is an agency of the District and is subject to the jurisdiction of the Public Employee Relations Board.

[3] The Union has a collective bargaining agreement with which has continued without amendment since September 30, 1995, and which is attached as Attachment A to the filed original of this complaint.

ANSWER: Respondent denies that the Union's collective bargaining agreement has continued without amendment since September 30, 1995. The parties successfully negotiated a successor contract, which was signed May 3, 1999 and effective through September 30, 2001. (See, Respondent Exhibit #1.)

[4] On or about March 14, 2002, representatives of CSA met with Johnnie Walker, President of the Union, along with representatives of other unions who represent employees at CSA.

ANSWER: Respondent admits the averments.

[5] At this March 14, 2002 meeting, CSA announced unilateral changes it was making to mandatory subjects of bargaining including, but not limited to, employee work hours and shift schedules and the use of personal and government vehicles to perform work duties. CSA announced that these changes would become effective in two (2) weeks.

ANSWER: Respondent denies the averments. This interpretation is solely that of the Complainant, an adverse party. Respondent did not announce unilateral changes to mandatory subjects of bargaining. Union representatives were consulted on March 14, 2002, regarding mental health services changes necessitated by the Mental Health Rehabilitation Services standards. Respondent denies announcing that the changes would become effective in two (2) weeks. (See, Respondent Exhibit #2, specifically, page 20 of 59.) Union representatives and employees have been informed that changes will be effective May 1, 2002.

[6] CSA did not give the Union advance notice or the opportunity to bargain over its unilateral changes prior to the announcement on March 14th.

ANSWER: Respondent denies the averments. This interpretation is solely that of the Complainant, an adverse party. Respondent has given the Union advance notice of pending changes. During the monthly scheduled Labor Leadership Meetings on November 27, 2001, December 18, 2001, and January 15, 2002, Juanita Price, Chief Executive Officer, CSA, Department of Mental Health, informed union representatives of the pending changes necessitated by law. Respondent has abided by the current collective

bargaining agreement between the parties, which provides in Article 7, Section 4 that, "The Employer will give the Union prior notice when there will be changes having an impact on terms and conditions of employment of the bargaining unit. When prior notice cannot be given, the Employer will notify the Union within 24 hours of occurrence."

[7] Since March 14, 2002, CSA has failed and refused to bargain with the Union over matters affecting wages, hours, and terms and conditions of employment.

ANSWER: Respondent denies the averments. Respondent has not failed or refused to bargain with the Union over matters affecting wages, hours, and terms and conditions of employment. Following the March 14, 2002 Consultation Meeting Union representatives received a March 19, 2002 letter from the Chief Executive Officer of the Community Services Agency, which invited individual Unions to initiate impact and effect bargaining over terms and conditions of employment. The March 19, 2002 letter requested that Union representatives notify the Department of Mental Health of their option to bargain by Friday, March 22, 2002. (See, Respondent Exhibit #3.) Respondent has not received any notice, either verbal or in writing, from the American Federation of Government Employees, Local 383.

[8] By the conduct alleged in paragraphs 4-8, CSA has failed and refused to bargain in good faith in violation of D.C. Code section 1-618.4 (a) (1) and (5).

ANSWER: Respondent denies that it has failed and refused to bargain in good faith. Respondent discussed changes at the monthly Labor

Management Meetings on November 27, 2001, December 18, 2001, and January 15, 2002 and sought input from the Union representatives. Respondent further provided Union representative an opportunity to bargain over changes in the March 19, 2002 letter.

[9] The Union did not provide a statement for this paragraph.

[10] The Union is aware of no related or other proceedings involving matters related to this complaint.

ANSWER: Respondent neither admits nor denies the averment. The information is solely within the knowledge of the Complainant, an adverse party, and therefore no response is required.

WHEREFORE, the Union asks the PERB to find that CSA's conduct constitutes an unfair labor practice and order that CSA:

a) Cease and desist from violations of D.C. Code section 1-618.4 (a) (1) and (5) in the manner alleged or in any like or related manner and bargain with the Union over the issues raised at the March 14th meeting;
b) Return and/or maintain all wages, hours, and terms and conditions of employment to or at the status quo until such time as CSA bargains with the Union;
c) Pay the Union's costs in this matter;
d) Post an appropriate notice to employees; and
e) Desist from or take such affirmative action as effectuates the policies and purposes of the Comprehensive Merit Personnel Act of 1978.

ANSWER: The statement is a request to which no response is required.

RESPONDENT'S AFFIRMATIVE DEFENSES

[1] The Complainant's Unfair Labor Practice complaint should be dismissed, because the complaint fails to state an unfair labor practice for which relief may be granted.

[2] The Complainant's Unfair Labor Practice complaint should be dismissed, because PERB lacks jurisdiction to grant the relief requested. Complainant's complaint is legally insufficient. The current collective bargaining agreement is an agreement that was entered into on May 3, 1999, between the Commission of Mental Health (currently Department of Mental Health) and Local 383, District 14, American Federation of Government Employees, AFL-CIO and Local 2095, District of Columbia Council 20, American Federation of State, County and Municipal Employees, AFL-CIO. Throughout the Agreement, AFGE Local 383 and AFSCME Local 2095 are jointly referred to as the "Union." Article 1 of the collective bargaining agreement states that AFGE Local 383 and AFSCME Local 2095 "hereinafter jointly referred to as the "Union"." Respondent notes that AFSCME Local 2095 has not joined with AFGE Local 383 to file this complaint. Complainant has not mentioned AFSCME Local 2095 as a party to this complaint, nor has Complainant mentioned AFSCME Local 2095 as a party to the collective bargaining agreement.

[3] The Complainant's Unfair Labor Practice complaint should be dismissed, because the complaint PERB lacks jurisdiction to grant the relief requested.

Respondent is operating within required standards of providing mental health care to consumers. Pursuant to the District of Columbia Code 1-618.8 (a) (5), Respondent has the right "to determine the mission of the agency, its budget, its organization, the number of employees, and the number, types, and grades of positions of employees assigned to an organizational unit, work project, or tour of duty, and the technology of performing its work..." Respondent is not precluded by any of the collective bargaining agreements with the unions, including Complainant from maintaining the efficiency of the District government operations entrusted to Respondent.

[4] The Complainant's Unfair Labor Practice complaint should be dismissed, because PERB lacks jurisdiction to grant the relief requested. Respondent has not required any changes that are inconsistent with the written terms and condition of the collective bargaining agreement.

[5] The Complainant's Unfair Labor Practice complaint should be dismissed, because PERB lacks jurisdiction to grant the relief requested. Respondent contends that this matter should be addressed through the collective bargaining negotiation process scheduled to begin on May 21, 2002.

[6] The Respondent further requests that PERB order the Complainant to pay Respondent's costs and expenses associated with responding to this frivolous complaint occasioned by the Complainant's false statements.

WHEREFORE, Respondent respectfully prays that Complainant's Unfair Labor Practice should be dismissed for failure to state a claim upon which relief can be granted.

Respectfully submitted,

District of Columbia Department of Mental Health

Ivy McKinley
Director, Human Resources
District of Columbia Department of Mental Health
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E Building, First Floor
Washington, D.C. 20032
(202) 645-3555

DATED: April 23, 2002

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing RESPONDENT'S ANSWER AND AFFIRMATIVE DEFENSES TO UNFAIR LABOR PRACTICE COMPLAINT was mailed first-class postage prepaid on April 23, 2002, to Melinda K. Holmes, 1300 L Street, N.W., Suite 1200, Washington, D.C. 20005.

Ivy McKinley

COLLECTIVE BARGAINING AGREEMENT

BETWEEN

AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES

LOCAL 2095

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

LOCAL 383

AND

COMMISSION ON MENTAL HEALTH SERVICES

Effective through September 30, 2001

Exhibit #1

TABLE OF CONTENTS

PREAMBLE

This Agreement is entered into this 3rd day of May, 1999, between the Commission on Mental Health Services (hereinafter referred to as the "Employer" or "CMHS") and Local 383, District 14, American Federation of Government Employees, AFL-CIO, and Local 2095, District of Columbia Council 20, American Federation of State, County and Municipal Employees, AFL-CIO (hereinafter jointly referred to as the "Union.")

ARTICLE 1

PARTIES TO THE AGREEMENT

Pursuant to authority contained in the D.C. Code, Subchapter XVIII, Labor-Management Relations, this Agreement is made between the Commission on Mental Health Services, and Local 2095, District of Columbia Council 20, American Federation of State, County and Municipal Employees (AFL-CIO) and Local 383, District 14, American Federation of Government Employees (AFL-CIO), hereinafter jointly referred to as the "Union."

ARTICLE 2

ACCORD OF RECOGNITION

Section 1:

This Agreement applies to: All non-professional, non-supervisory employees in the Commission on Mental Health Services, excluding management executives, confidential employees, supervisors, non-professional employees of the Construction, Electrical, Mechanical; Preventive Maintenance, Garage, and Fabric Care Sections, any employees engaged in personnel work in other than a purely clerical capacity or employees engaged in administering the provisions of Comprehensive Merit Personnel Act.

Section 2:

The Union is the exclusive representative of all employees in the above-referenced unit and, as such, is entitled to act for all employees in the unit and is responsible for representing the interests of all such employees without discrimination and without regard to union membership.

Section 3:

Issues involving unit definition and its scope may be referred by either party to the Public Employee Relations Board for resolution under appropriate procedures.

ARTICLE 3

MANAGEMENT RIGHTS

Section 1:

Management Rights in Accordance With the Comprehensive Merit Personnel Act (CMPA). D.C. Code Section 1-618.8 of the CMPA establishes management rights as follows:

"(a) The respective personnel authorities (management) shall retain the sole right in accordance with applicable laws and rules and regulations:

(1) to direct employees of the agencies;
(2) to hire, promote, transfer, assign and retain employees in positions within the agency and to suspend, demote, discharge or take other disciplinary action against employees for cause;
(3) to relieve employees of duties because of lack of work or other legitimate reasons;
(4) to maintain the efficiency of the District government operations entrusted to them;
(5) to determine the mission of the agency, its budget, its organization, the number of employees and the number, types and grades of positions of employees assigned to an organizational unit, work project or tour of duty, and the technology of performing its work; or its internal security practices; and
(6) to take whatever actions may be necessary to carry out the mission of the District government in emergency situations.

(b) All matters shall be deemed negotiable except those that are proscribed by this title...."

Section 2: Impact of Exercise of Management Rights:

Management rights are not subject to negotiations; however, in the Employer's exercise of such rights, the Union may grieve where there has been an adverse impact upon employees regarding terms and conditions of employment or a specific violation of a separate Article of this Agreement.

ARTICLE 4

EQUAL EMPLOYMENT OPPORTUNITY

Section 1:

The Employer and Union agree to cooperate in providing equal opportunity for all employees; in guarding against unlawful discrimination because of race, color, religion, sex, age, marital status, physical handicap, national origin, union membership or non-membership, political affiliation, personal appearance, sexual orientation, family responsibilities, matriculation, or as otherwise provided by law; and in promoting equal opportunity through a positive and continuing effort.

Section 2:

The Employer agrees to vigorously continue the implementation of its Equal Employment Opportunity Program as approved by the Director, D.C. Office of Human Rights. For the purpose of this Agreement, the Department's Affirmative Action Plan will be observed. Progress reports will be sent to the Union periodically as to the implementation of the Affirmative Action Plan.

Section 3:

The Union shall designate an Affirmative Action Coordinator. The Department's EEO Officer shall notify the Affirmative Action Coordinator to attend meetings of the Department's Affirmative Action Counselors, and be permitted to meet with the Department EEO officials to discuss implementation of the Affirmative Action Plan including Department policies and programs.

Section 4:

To promote equal opportunity, the Employer will continue to conduct an affirmative action program, including an affirmative action plan formulated and implemented in accordance with applicable laws and regulations.

Section 5:

The Employer agrees to provide the Union with a reasonable number of copies of the Affirmative Action Plan. Additionally, the Employer will provide a copy of the EEO complaint procedure to an employee upon his/her request.

Section 6:

The Employer and the Union will respect an employee's right to file a formal discrimination complaint under the EEO Complaint Processing Procedure. It is understood that prior to filing such a complaint, an employee must consult an EEO Counselor and follow the prescribed counseling procedure.

Charges of discrimination shall be considered by the appropriate administrative agency having jurisdiction over the matter and shall therefore not be subject to the negotiated grievance procedure.

Section 7:

An employee may contact any EEO Counselor at the CMHS on a potential EEO complaint. The Employer will publicize the names of these counselors, indicating how they may be contacted.

Section 8:

Final selection and appointment of EEO Counselors is a higher-level agency management responsibility. However, the Employer agrees that the Union has a right to submit names of unit employees to the Employer for consideration. Further, the Employer agrees to consider these nominees, using the same criteria as are used for any other nominees. The Department will notify the Union of those Union nominees forwarded. The Union will be notified of the names of employees selected as EEO Counselors.

Section 9:

It is understood that official time for preparation and presentation of a discrimination complaint shall be in accordance with applicable EEO regulations. Grievances concerning the application of these provisions shall be considered by the appropriate administrative agency having jurisdiction over the matter.

Section 10:

The Union will be provided a copy of the most recently compiled CMHS statistical report on EEO.

Section 11:

In the event the Employer conducts labor relations training for EEO Counselors, a representative of each Union will be afforded the opportunity to present the Union's viewpoint on labor relations implications of EEO counseling.

ARTICLE 5

RIGHTS OF EMPLOYEES

Section A – General:

Employees may bring issues of concern which affect working conditions to their supervisor. The Employer and Union agree that Employees shall be free from restraint, interference, coercion, or discrimination in the exercise of their right to organize and designate representatives of their own choosing for the purpose of collective bargaining and the presentation of grievances.

Section B - Classification:

1. An employee in the bargaining unit may discuss and review his her job classification in terms of title, series, grade or description with the appropriate supervisor and the Office of Human Resources.

Section C - Job Descriptions:

1. Every employee within the unit will be supplied with a copy of their official job description upon request.

   Upon request, the Union/employee will be supplied with a copy of each job description when needed for a grievance or classification appeal.

   Employees will be informed of any changes in their job description affecting their position prior to implementation.

2. Each job description shall specify the major duties and responsibilities of the position. When the phrase "other related duties as assigned" is included in a position description, it will not be construed to include unrelated duties which are regular and recurring in nature and which would adversely affect the employee's title, grade and series. If the employee's title, grade, and series would be adversely affected, the employee will have the right to grieve such action.

Section D - Bond and Charity Drives:

Employee participation in bond and charity drives will be strictly voluntary.

ARTICLE 6

UNION REPRESENTATION

Section 1:

The Union shall be given the opportunity to be represented at formal discussions between the Employer and employees or employee representative concerning implementation of this contract.

Section 2:

The Union may designate up to a total of 5 Chief Shop Stewards (who may also be officers of the Union) who will be empowered to process and settle grievances with the Employer. The Union will assign each Chief Shop Steward (CSS) to represent a specific CMHS organizational area, normally within the steward's Division. If a CSS is not available, the employee will contact an officer of the Union. The officer will designate a CSS to represent that employee and notify the supervisors of both the CSS and the employee involved.

Section 3:

The Union will supply the Employer, in writing, and maintain with the Employer on a current basis a complete list of Union officers, Chief Shop Stewards and the CMHS organizational area each CSS is assigned to represent. Upon receipt from the Union of the information required under this section, the Employer will distribute the listing of Union officers and CSSs.

Section 4:

The Union will notify the Employer, in writing, of non-employee officials of D.C. Council 20 and District 14 who are authorized to represent the Union in dealings with the Employer. Such dealings will be through the designated CMHS representative, who shall make appropriate arrangements for visits to the Employer facilities by D.C. Council 20 or District 14 representatives on official business. The Union will notify the employer in writing of non-employee individuals and employees who the Union authorizes as their representative on such matters as they shall designate.

Section 5:

A Chief Shop Steward who desires to leave his or her place of work for a duty arising from this Agreement must contact his or her immediate supervisor for permission as far in advance as practical, stating the nature of the matter, the place(s) to be visited, and a reasonable estimate of the time of return. If the duty involved contacting an employee,

when the employee has designated the CSS in accordance with this Agreement, the CSS will contact the immediate supervisor of such employee and obtain that supervisor's permission to contact or meet with the employee. If the immediate supervisor is not available, permission may be given by the next level supervisor. Such permission will be given unless the work situation or an emergency dictates otherwise; and a confidential place for discussing the matter will be made available upon request. The CCS will report back to his or her supervisor upon completion of duties arising from this Agreement and return to his or her place of work, and will lose no pay or other benefits as a result of such absences, provided the total time thus spent is kept at a minimum.

Section 6:

The Union acknowledges that the Employer retains the right to change the work shifts of Union representatives. However, it is agreed that the Employer will not change work shifts so that the effectiveness of the Union will be unfairly impaired. The Employer will notify the Union President in writing, five (5) work days in advance (except, in emergencies, less notice may be given) and, upon request, consult with the Union prior to effecting changes in work locations or work shifts (other than changes made as part of a regular shift rotation) if such changes are expected to exceed 30 calendar days.

Section 7:

Solicitation of membership, dues, or other internal business of the Union shall not be conducted during the duty hours of any of the employees concerned.

Section 8:

Supervisors will introduce new bargaining unit employees to Chief Shop Stewards assigned by the Union to represent their work areas. When formal Administration-level orientations are held for new bargaining unit employees, the Union shall have an opportunity to explain Union representation and responsibilities.

ARTICLE 7

CONSULTATION

Section 1:

It is agreed that matters appropriate for consultation between the parties are policies, regulations, and practices related to working conditions. The Employer and the Union, through appropriate representatives, shall meet at reasonable times and consult in good faith. It is understood that appeals or grievances of employees shall not be the subject of discussion at these meetings, nor shall the meeting be for any other purposes, which modify, add to, or detract from the provisions of this Agreement. The Labor-Management meetings are established to discuss different points of view and exchange information on

working conditions, terms of employment, matters of common interest, or other matters which either party believes will contribute to improvement in the relations between them.

Section 2:

In addition to other existing appropriate Labor-Management meetings, the parties agree to establish Labor-Management meetings at the Administration level. Such meetings will be held quarterly, unless mutually agreed to do otherwise. The Union President and Chief Shop Steward for that particular Administration or designee shall represent the Union at these meetings. The Union will use its best efforts to submit an Agenda and supporting documents, if any, to the Employer in a reasonable amount of time prior to the scheduled meeting.

Section 3:

Both the Employer and the Union recognize the importance of Chief Shop Stewards and supervisors as key people in maintaining a constructive labor-management relationship. The parties agree to encourage constructive dealings and facilitate meetings between supervisors, program managers, and Division Heads, as appropriate, and Chief Shop Stewards, to resolve problems and facilitate labor-management communication at the work level, on personnel policies, practices and working conditions.

Section 4:

The Employer will give the Union prior notice when there will be changes having an impact on terms and conditions of employment of the bargaining unit. When prior notice cannot be given, the Employer will notify the Union within 24 hours of the occurrence.

Section 5:

The employer will respond in writing to issues presented by the Union in writing.

ARTICLE 8

UNAUTHORIZED ACTIVITIES

Section 1:

It shall be unlawful for any CMHS employee to participate in, authorize or ratify a strike against the CMHS. At no time, however, shall employees be required to act as strikebreakers. The term "strike", as used herein, means any unauthorized concerted work stoppage or slowdown. No lockout of employees shall be instituted by the Employer

during the term of this Agreement except that the Employer, in a strike situation, retains the right to close down facilities to provide for the safety of employees, equipment or the public.

ARTICLE 9

ATTENDANCE AND LEAVE

A. Annual Leave:

1. Annual leave is a benefit provided by law. Except as otherwise provided by this Article, employees shall earn and use annual leave in accordance with the provisions of the District of Columbia Government Comprehensive Merit Personnel Act and current practice as of the effective date of the signing of this contract. Employees are entitled to take annual leave subject to the approval of the employee's supervisor who will not deny such leave for arbitrary or capricious reasons.

   The Employer and the Union agree that conflicts between the needs of the Employer and needs of the employees may be minimized if employees meet their obligation to request annual leave in a timely manner in accordance with the District personnel regulations, and supervisors meet their responsibility to plan and effectively schedule annual leave for use by employees throughout the leave year.

For the purpose of this Article, annual leave shall be categorized as follows:

a. Scheduled Leave—Vacation leave or other annual leave that is approved before posting or otherwise approved in advance of the administrative workweek (Sunday-Saturday) during which the leave is to be taken.
b. Unscheduled Leave (Emergency Annual Leave) -- Annual leave for personal purposes or emergency situations that the employee could not have planned for, or anticipated, in advance of the administrative workweek, that require the employee's absence from duty.

2. Scheduled Annual Leave:

   a. Vacation—By April 1, except in unusual circumstances, leave-approving officials will schedule, in writing, the approved annual leave for a vacation for each employee based on the written requests that have been received by March 1 of that year. Supervisors will record the date of receipt of each request. Conflicts in requests among employees of similar skills and levels of

responsibility within a unit will be resolved on a first come, first served basis (based on the date of receipt of the conflicting requests). In the event conflicting requests are received on the same date, length of service will be used as a tiebreaker. Only in emergency situations may the leave be changed and in such case the employee must be notified of the reason(s) for the change as soon as possible. Employee requests received after March 1 will be considered in light of the needs of the service (with earlier vacation requests receiving priority); and the employee will be given an answer within thirty (30) days.

b. Other Annual Leave—Employees requesting annual leave (scheduled leave) for other than vacations should request such leave in accordance with the provisions of this Article and as far in advance as practicable. Such annual leave requests will be considered in light of both the needs of the requesting employee and the needs of the unit.

3. Unscheduled Annual Leave:

Employees must request leave for emergency situations and personal purposes as soon as he or she becomes aware of the emergency situation or determines the needs. The supervisor will respond to the request as soon as possible and will give consideration to the needs of the employee, as well as the needs of the unit. Such requests for leave will not be denied for arbitrary or capricious reasons. The employee's supervisor may request the reason for the annual leave request, however, if the employee elects not to divulge the reason for the request, the supervisor will make the decision based on the information available.

4. Advance Annual Leave:

Subject to the current practice advance annual leave may be granted to the extent that such leave will accrue to the employee during the remainder of the current leave year or in the time remaining on his or her appointment, whichever occurs sooner.

B. Sick Leave:

1. Generally—Sick leave is a benefit provided by law. Except as otherwise provided by this Article, employees shall earn and use sick leave in accordance with the provisions of the District of Columbia Government Comprehensive Merit Personnel Act.

   Sick leave is a period of absence with pay granted employees in any of the following circumstances:

a. When incapacitated for the performance of duties by sickness, injury, or pregnancy and confinement or for medical, dental, or optical examination or treatment;

b. When a member of the immediate family of an employee is afflicted with a contagious disease and requires the care and attendance of the employee; or

c. When, through exposure to contagious disease, the presence of the employee at his or her post of duty would jeopardize the health of others.

The Union and the Employer recognize the insurance value of sick leave and agree to encourage employees to conserve sick leave so that it will be available to them when incapacitated for the performance of duty under the above-stated circumstances.

2. Requesting Sick Leave:

Employees unable to report for work for their tour of duty due to one or more of the reasons stated in Section B.1., above, will request sick leave from the appropriate leave-approving official. If the leave-approving official is not on duty, another official with authority to act on requests will be on duty. Sick leave requests may be made in person on a properly completed SF-71 if the requesting employee is on duty at the time of the request, or by telephone or other appropriate means if the employee is not on duty at the time of the request.

a. Employees who have a pattern of abusing sick leave must call in one hour prior to the start of their shift and provide a detailed explanation for the reason for their requested leave.

b. Employees who become ill or otherwise incapacitated prior to their scheduled tour of duty shall request sick leave as soon as practicable, but not later than one hour before the start of their scheduled tour of duty. Employees will be placed in a leave without pay status without sufficient reason for meeting this requirement. After three (3) late calls within a calendar year the employee will be placed on a letter of leave restriction.

c. Employees will keep their supervisors informed of the expected date of their return to duty, providing as much advance notice as practical of a change in the expected date of their return. An employee who requests a certain amount of sick leave (i.e., eight (8) hours) is expected to call back to request additional sick leave if more is needed. Leave-approving officials (or alternates) will not arbitrarily restrict the amount of sick leave granted (i.e., no more than eight (8) hours).

d. When an employee requests sick leave, he or she will indicate the general nature of the incapacitation (or other reason for the request) and indicate his or her estimated date of return to duty. If an employee calls in to request sick leave and is informed that no leave-approving official (or alternate) is available to take the call, the employee will leave a message that he or she is requesting sick leave, indicate the general nature of the incapacitation (or other reason for the request) and indicate his or her estimated date of return to duty.

3. Granting Sick Leave:

a. Accrued sick leave, properly requested and supported by administratively acceptable evidence, will be granted in the situations specified in Section B.1., above. In cases where the nature of the illness is such that an employee did not see a medical practitioner, a medical certificate may not be required if the employee provides an acceptable explanation.

Medical documentation will be required for extended absences of abuse more than three (3) workdays. If an employee has a pattern of abuse or is on a letter of leave restriction, medical documentation may be required on the first day of absence.

b. Information given by an employee to a supervisor to support a grant of sick leave shall be treated as confidential information and provided only to those with a need to know.

4. Advance Sick Leave:

An employee who is incapacitated for duty because of serious illness or disability may be advanced sick leave for up to thirty (30) days if there is a reasonable expectation that the employee will return to duty. An employee's request for advance sick leave must be in writing and must be supported by medical documentation acceptable to the leave-approving official. The request will be submitted to the immediate supervisor and forwarded through the channels to the official authorized to approve the request. The approving official will act on the request in a timely manner.

C. Leave Without Pay (LWOP):

1. Subject to the applicable personnel regulations, employees may be granted leave without pay. Normally, the initial period of leave without pay shall not exceed twelve (12) months.

2. The retention and accumulation of rights, benefits and privileges by employees who are on leave without pay shall be subject to the applicable personnel regulations.

D. Absence Without Leave (AWOL):

1. Subject to the applicable personnel regulations, employees may be charged absent without leave (AWOL), which is a non-pay status, for any absence from duty not authorized by a proper leave-approving authority.

2. AWOL is charged when employees are absent without permission or have not notified their supervisor or provided satisfactory explanation or documentation for the absence from duty. An AWOL charge may be changed later to an appropriate type of leave if the leave-approving official determines that the employee has satisfactorily explained the absence or presented acceptable documentation.

3. Occasional unavoidable or necessary absence of less than one hour, including tardiness, with satisfactory explanation, may be excused without charge to leave or, if the circumstances warrant, the employee may request and be granted annual leave instead of being charged AWOL. An employee who is to be granted annual leave or placed in an AWOL status for unexcused tardiness shall be informed of the amount of time to be charged before reporting to his/her work location (if different from reporting site). The amount charged will not exceed the minimum charge (one hour) necessary to cover the period of absence. The employee will not be required to report to the work location (if different from the reporting site) or allowed to perform work during any portion of the period he/she is charged for the absence. Upon arrival to duty, an employee who is tardy must immediately report to his/her leave-approving official or that official's designee.

E. Excused Absences:

1. Subject to the applicable personnel regulations, employees may be granted an excused absence.

2. An excused absence is an absence from duty administratively authorized without loss of pay and without charge to leave. An excused absence is ordinarily authorized on an individual basis, except where an establishment is closed, or a group of employees is excused from work for various purposes.

F. Managing Attendance and Leave:

1. In monitoring leave used by employees and to assure its proper usage, a leave granting official shall be on duty at all times. The employer will identify to employees those individuals who are proper leave approving officials.

Supervisors should review leave records for factors which may indicate a problem, such as:

a. excessive leave use;
b. zero leave balances;
c. frequent requests for short periods of leave without pay;
d. pattern of using leave in small increments as quickly as it is accrued;
e. persistent requests for unscheduled leave; and
f. repeated failure to follow proper procedures for requesting leave or for notifying the supervisor of unanticipated absences.

While such factors may indicate a problem, there may also be mitigating circumstances. (For example, a zero leave balance may be the result of a major illness or surgery.) As indicated below, mitigating circumstances are to be taken into account.

2. Employees with chronic health problems or with personal circumstances which necessitate frequent or unpredictable use of leave are encouraged to discuss such situations with their supervisor and are expected to comply with reasonable documentation requirements. To avoid unnecessary misunderstandings and difficulties concerning leave usage, an employee should bring such health problems or personal circumstances to the attention of his or her supervisor as soon as possible.

3. If an employee's leave usage is a problem and the employee has not raised the issue of mitigating circumstances, the supervisor will talk with the employee and attempt to determine whether there are mitigating circumstances. If mitigating circumstances are found to exist (as a result of either the employee's or supervisor's initiative), the supervisor will take them into consideration in efforts to work with the employee to resolve the leave problem.

4. If no mitigating factors are found to exist, or if reasonable efforts to work with the employee to resolve the leave problems are unsuccessful, the supervisor will discuss the leave problem and counsel the employee on leave requirements and procedures. Such counseling will be documented.

5. After counseling, the employee will be given a reasonable opportunity (e.g., up to thirty (30) days) to improve his or her attendance record. This opportunity will be afforded the employee once in a year, from the date of the initial counseling session. If the problem persists or recurs after the counseling and the opportunity to improve, the supervisor may refer the employee to the Employee Assistance Program and/or place the employee on leave restriction. (This does not preclude earlier referral to the Employee Assistance Program when warranted.) These actions will be communicated to the employee in writing. The supervisor will also inform the employee in writing if improvement has been satisfactory.

6. A letter of leave restriction is a written communication to an employee, placing restrictions on the employee's future use of leave and stating the requirements the employee must follow in requesting and obtaining approval of leave. The restrictions should apply to the type(s) of leave for which there is a problem. The purpose of the letter is to assist the employee in bringing about an improvement in his or her attendance record. While failure to comply with the restrictions may result in additional discipline, a letter of leave restriction has the status of a written warning.

7. Leave restrictions shall be imposed for an initial period of two (2) months. By the end of the two-month period, the supervisor will review the employee's attendance since the letter was issued. If the employee's leave usage has been acceptable during that period, the supervisor must notify the employee in writing that the restrictions have been lifted. On the other hand, if the employee has failed to comply with the restrictions, the supervisor should consider continuation of the restrictions for an additional period of two (2) months and discipline. If the employee's attendance has improved during the initial two-month period, but is still not satisfactory, the supervisor should consider extending the leave restrictions for two (2) months and deferring the decision on discipline. However, leave restrictions should not be extended repeatedly without further action. In any event, the supervisor must notify the employee in writing when leave restrictions are extended.

8. Exceptions to the above procedures may be warranted in exceptional circumstances.

9. Any copies of a leave restriction letter or extension will be safeguarded and made available only to persons who have an official need to know. Copies must not be filed in the employee's Official Personnel Folder.

G. Union Business:

1. Employees elected to any Union office or selected by the Union to do work which takes them from their employment with the Employer may at the written request of the employee and the Union be granted a leave of absence without pay.
The initial leave of absence shall not exceed one (1) year. Leave of absence for Union officials may be extended for similar period. No more than one (1) employee of the bargaining unit shall be on such leave at the same time. Contribution of continued benefits shall be in accordance with appropriate regulations.

2. Attendance at Union-sponsored programs will be on approved annual leave or leave without pay, unless administrative leave has been approved by the Office of Employee and Labor Relations.

ARTICLE 10

CIVIC RESPONSIBILITIES

Section 1:

In the event an employee is called for court service as a juror or witness, the Employer will grant appropriate leave (court leave, annual leave or leave without pay) or excuse the employee from duty without charge to leave, as is authorized by applicable District personnel regulations for the type of court service involved.

Section 2:

If an employee is called for court service, he/she shall promptly notify the Employer by showing a copy of the court order, subpoena or summons to his/her leave-approving official and requesting leave or excused absence and upon return to duty will present to his/her leave-approving official a signed court service timecard or other satisfactory written evidence of the time served on such duties.

Section 3:

Employees scheduled to work on any election day who are eligible to vote in such election shall be granted sufficient time off to vote in accordance with applicable regulations and such employees shall suffer no deduction in leave or pay for time so spent, provided such leave is approved in accordance with District personnel regulations.

ARTICLE 11

HOURS OF WORK

Except as otherwise provided by this Article, the establishment of workweeks and work schedules shall be in accordance with the provisions of the District of Columbia Government Comprehensive Merit Personnel Act (CMPA).

A. As a general rule, the regular basic workweek is established at not more than 40 hours per week and is comprised of five, 8-hour days within the standard

administrative workweek, beginning with Sunday and extending through Saturday. A lunch period of 30 minutes is provided.

Exceptions to this general rule are permitted, and have been established, pursuant to provisions of the CMPA and DPM (i.e., firefighter scheduling, variations in work schedules for educational purposes, and alternative work schedules).

Such exceptions must be approved by an official with authority to authorize exceptions to the general rules. The Union will be given advance notice (when alternative work schedules are proposed) and shall be given the opportunity to consult.

B. Employees will report to work, ready to perform the duties of his or her position, at the scheduled starting time of his or her tour of duty. If the designated reporting site differs from the location where an employee will actually be working, the employee will be allowed a reasonable amount of time to proceed directly from the reporting site to his or her work location.

Information relating to an employee's specific leave record/ status shall not be publicly displayed on time sheets, check-in sheets, or work schedules. (This provision does not apply to those employees in work units participating in an alternative work schedule.) The leave status of an employee who is absent on leave, but who is not on a scheduled day off, may be indicated on publicly displayed time sheets, check-in sheets, or work schedules by using the code "L" to indicate the employee is on leave.

C. Where employees are required to work rotating shifts, work schedules showing the employee's scheduled workdays and non-workdays will be posted by the 15th day of the preceding month in appropriate work locations and the supervisor's office.

1. An employee requesting a change of shift will submit a written request to his or her supervisor by the twenty-third day of the month prior to the posting. The request will include sufficient information for an informed judgment to be made.

2. Requests for a change of shift received after the twenty-third day of the month preceding the posting of the work schedules will be considered by the Employer.

3. Employees who are to be reassigned (i.e., non-temporary lateral assignment to another unit) or whose shifts are to change will be notified by the fifth day of the preceding month, except in some cases (e.g., reassignments due to reduction in force, unavailability of the employee to be notified, need to replace an employee who resigns or otherwise will not be available as planned, and other circumstances beyond the control of Management) later

notification may be necessary. Involuntary changes will be made in a fair and equitable manner, consistent with the needs of the Employer.

4. In exercising the right to assign employees to tours of duty, supervisors will give careful consideration to the expressed desires of individual employees.

D. An employee will not be required to work with less than ten (10) hours between rotating shifts except with the expressed consent of the employee or in an overtime situation or when assigned to an established relief shift. In the regular schedule, employees will not be required to work more than six (6) consecutive days, but may do so with their expressed consent.

E. After schedules are posted, involuntary shift changes will not normally be made without advance notice. When such a change is to be made, employees will normally be given one one-week advance notice.

F. Supervisors will allow each employee two (2) scheduled daily 15-minute rest periods, except in critical or emergency circumstances when a rest period would unduly interfere with essential activities of the work unit. These rest periods shall be administered consistent with current practice. For employees whose tours of duty include a meal period, such meal periods will not be scheduled during the first two or last two hours of their scheduled tours of duty, except in critical or emergency circumstances. (This does not preclude the employee from requesting and the appropriate supervisor from approving an exception.)

G. The Employer and the Union agree that no employee should be required to use mealtime or after duty time for necessary personal clean up. Accordingly, where personal clean up is required before meals or at the end of the workday, supervisors will provide adequate on-the-clock time.

H. The Employer retains the right to schedule employees in accordance with this Article so that staffing needs will be met. When consistent with staffing needs, employees shall be granted:

1) A two-day weekend off every other weekend with a consistent day off (i.e., Tuesday, Wednesday or Thursday) during the period covered by the schedule; or

2) A three-day weekend off every third weekend; or

3) A three-day weekend every other weekend;

ARTICLE 12

ADMINISTRATION OF OVERTIME

Section 1:

Overtime work shall be equally distributed among employees who are qualified to perform the work; however, an employee who has a documented poor attendance record (written warning or higher level of discipline) may be limited in the distribution of overtime. Specific employee qualifications shall be considered when decisions are made on which employees shall be called for overtime work.

Section 2:

Management will solicit volunteers when overtime work is required. The Employer will solicit volunteers for overtime in the following order: from those employees on duty in the work unit/work area involved and then from the building or pool of individuals who have made it known that they are available to work overtime. In the event a sufficient number of qualified volunteers are not available, overtime work will be assigned in reverse order of CMHS seniority. Instances of hardship should be presented to the supervisor and shall be considered on a case-by-case basis.

ARTICLE 13

SAFETY AND HEALTH

Section 1 - Working Conditions:

A. The CMHS shall provide and maintain safe and healthful working conditions for all employees as required by applicable laws. It is understood that CMHS may exceed standards established by regulations consistent with the objectives set by law. The Employer will make every effort to provide and maintain safe working conditions; AFSCME/AFGE will cooperate in these efforts by encouraging its members to work in a safe manner and to obey established safety practices and regulations.

B. Matters involving safety and health will be governed by the D.C. Occupational Safety and Health Plan in accordance with Subchapter XXI of the Comprehensive Merit Personnel Act (1980, as amended).

C. The CMHS shall furnish and maintain each work place in accordance with standards provided within this Section.

Section 2 - Transportation of Patients:

The Employer agrees that appropriate measures will be employed when transporting patients. The number and types of escorts will depend upon the number and category of residents being transported and the nature of the trip.

Section 3 - Reporting Unsafe Conditions:

A. If an employee observes a condition, which he or she believes to be unsafe, the employee should report the condition to the immediate supervisor.

B. If the supervisor and employee agree that a condition constitutes an immediate hazard to the health and safety of the employee, the supervisor shall take immediate precautions to protect the employee.

C. If the supervisor and employee do not agree that a condition constitutes an immediate hazard to the health and safety of the employee, the matter may be immediately referred by the employee to the next level supervisor or designee or may file a grievance. The supervisor or designee shall meet as soon as possible with the employee and his or her AFSCME/AFGE representative, and shall make a determination.

D. Employees shall not be required to operate equipment that has been determined by the Employer or the appropriate D.C. Safety Officer to be unsafe to use, when by doing so they might injure themselves or others.

Section 4 - Medical Service: On-the-Job Injury:

A. The CMHS shall make first-aid kits reasonably available for use in case of on-the-job injuries. If additional treatment appears to be necessary, the CMHS shall arrange immediately for transportation to an appropriate medical facility.

B. The need for additional first-aid kits will be an appropriate issue for Safety Committee determination. Recommendations of the Safety Committee will be referred to the appropriate CMHS officials.

Section 5 - Safety Devices and Equipment:

Protective devices and protective equipment shall be provided by the CMHS and shall be used by the designated employees.

Section 6 - Safety Training:

The CMHS shall provide safety training to employees as necessary for performance of their job. Issues involving safety training may be presented to the Safety Committee.

Section 7:

The Employer shall, where appropriate, provide training regarding appropriate health guidelines governing communicable diseases.

Section 8 - Safety Committee:

A. The President of AFGE Local 383 and the President of AFSCME Local 2095 and two Chief Shop Stewards shall be representatives to the Safety Committee.

B. The Safety Committee shall:

1. Meet on a mutually agreeable basis. Prior to a regularly scheduled monthly meeting, labor and Management must submit their respective agendas to each other at least five (5) days in advance;

2. Conduct safety surveys, consider training needs, and make recommendations to the Receiver and Administration Head; and

3. Consult with and advise the Receiver and Administration Head.

B. Final reports from the Receiver (or designees) shall be provided to the Safety Committee on all safety matters initiated by the Committee.

C. Safety Committees may be reorganized upon agreement of both parties.

Section 9 - Employee Health Services:

Employees covered by this Agreement shall have access to employee health services consistent with the Comprehensive Merit Personnel Act (D.C. Law 2-139).

ARTICLE 14

LIGHT DUTY

Section 1:

The Employer agrees to provide light duty assignments for employees injured on the job provided that the Employer determines that such work needs to be performed.

The employee will submit the request to his/her immediate supervisor as far in advance as practical. The request will be supported by necessary and relevant medical documentation, including the nature of the disability, the specific medical limitations, and the expected duration

If additional medical documentation is needed, the Employer will inform the employee, in writing, specifically what information is required to decide upon the employee's request. The employee will instruct his/her physician to cooperate in all respects with the employer's efforts to determine the extent and nature of the employee's ability to perform any functions in the light duty position.

If the Employer determines that no such light duty work needs to be performed, the Employer will inform D.C. Workers Compensation.

ARTICLE 15

FACILITIES AND SERVICES

Section 1:

Within each Division or work area, the Employer will provide bulletin boards and labeled containers for Union use only, located in accessible places available to employees, for the posting and distribution of appropriate Union literature, correspondence, and notices. Posting and distribution of Union material will be limited to the space provided and to the non-duty hours of the employees distributing and receiving the material. The material will be identified as Union material and will contain a removal date. Material containing propaganda against or attacks upon an Agency, individual, or activity of the District government will not be posted or distributed.

Section 2:

The Union and the Employer shall share equally the cost for printing and distribution of the contract.

Section 3:

The Union will ensure that each employee covered by the provisions of this Agreement receives a copy. This includes employees hired subsequent to this Agreement going into effect.

Section 4:

Union requests for use of facilities for meetings shall be addressed to the Employer's designated representative, shall contain the information prescribed by the Employer, and shall be submitted as far in advance as practical.

Section 5:

The Employer agrees to continue to provide lockers and/or lounge space for employees in facilities where they have already provided them.

ARTICLE 16

IDENTIFICATION DEVICES

Section 1:

The Employer agrees that employees may wear, on their uniform or other work clothing, while on duty, an unobtrusive membership pin indicating membership in any labor organization, provided that such pin is not larger than one and one-quarter inches in diameter, bears no campaign propaganda, and the wearing of such pin will present no hazard or potential hazard to the employee or to patients.

ARTICLE 17

PROMOTION PROGRAM

Section 1:

Promotion bulletins announcing bargaining unit positions which are scheduled to be filled under competitive promotion procedures will be posted on bulletin boards for at least ten (10) calendar days prior to the closing date. Promotion bulletins will indicate the area of consideration, duties of the position, qualifications required, method of application, and statement of equal opportunity. Copies of all vacancy announcements, cancellations, corrections or amendments shall be provided to the Union.

Section 2:

The area of consideration will be in accordance with the promotion opportunity announcement.

Section 3:

If qualifications are equal between external and internal applicants, the internal applicant will be awarded the job. If qualifications between internal applicants are equal, the employee with the most CMHS total years of service (seniority) will be awarded the job. Performance appraisal ratings and disciplinary and absenteeism records of internal candidates are recognized as factors in the evaluation process.

Section 4:

Unsuccessful applicants for position vacancies will be provided as statement giving the reasons for their non-selection.

ARTICLE 18

DISCIPLINE

Section 1:

Disciplinary actions shall be taken only for just cause and in accordance with the principles of progressive discipline. If a supervisor has reason to discipline an employee, it shall be done in a manner that will not embarrass the employee before other employees or the public.

Section 2:

Cause for discipline is as follows:

a. Fraud in securing appointment or falsification of official records;
b. Incompetency;
c. Inefficiency;
d. Inexcusable neglect of duty;
e. Insubordination;
f. Dishonesty;
g. Drunkenness on duty;
h. On-duty use of drugs not prescribed and/or obtained illegally;
i. Inexcusable absence without leave;
j. Conviction of a felony. A plea or verdict of guilty, or a conviction following a plea of nolo contendere, to a charge of a felony is deemed to be a conviction within the meaning of cause under this section...;
k. Discourteous treatment of a patient, the public, a supervisor or other employee;
l. Improper political activity, except as otherwise permitted by law or the Constitution (Hatch Act violations shall be referred to the Special Counsel of the Merit System Protection Board);
m. Willful disobedience except as authorized by law;
n. Misuse, mutilation, or destruction of District property, public records, or funds;
o. Refusal to take and subscribe any oath or affirmation which is required by law in connection with employment;
p. Other conduct during and outside of duty hours that would affect adversely the employee's or the agency's ability to perform effectively;
q. Engaging in a strike;
r. Misuse of official position or unlawful coercion of employee for personal gain or benefit;
s. Lack of dependability;
t. A finding by the Office of Employee Appeals, the Office or Commission of Human Rights or a court of competent jurisdiction in the District of Columbia that the employee has engaged in violation of guarantees in Title 1, Chapter 6, Subchapters I and VII, D.C. Code (1981), in the performance of that employee's official duties;
u. A finding that the employee has violated the provisions of Title 1, Chapter 6, Subchapter XIX, or Section 1-616.3, D.C. Code (1981); or
v. Conviction of any crime related to an employee's position. (In addition, the employer may take action against an employee in accordance with Section 1654 of the CMPA).

Section 3:

a.) Except for an emergency disciplinary action as defined in the Comprehensive Merit Personnel Act, employees shall receive fifteen-(15) days notice for suspensions of 10 days or more and for removals.

b.) Except for an emergency as defined in the Comprehensive Merit Personnel Act, an employee may submit a written response to a notice of a proposed disciplinary action within three (3) workdays of the notice of proposed disciplinary action.

Section 4:

a.) Employees shall receive a written statement of the cause(s) for the imposition of discipline.

b.) Employees shall be entitled to submit a written statement on their views of the discipline.

c.) For suspensions of 10 days or more and terminations, if a grievance has been filed, a grievance meeting shall take place prior to the implementation of the discipline.

d.) In any investigating meeting with the employee, the Union will be given an opportunity to be present.

e.) All disciplinary actions shall be copied to the Union.

f.) No disciplinary action shall commence after the time the Employer reasonably knew or should have known of the occurrence leading to the disciplinary action.

Section 5:

a) Grievances under this Article must be filed within ten (10) days of the proposed action.

b) An employee may use the grievance procedure or the Office of Employee Appeals, but not both. The filing of a grievance determines the use of Office of Employee Appeals or this contract.

ARTICLE 19

PERSONNEL FILES

Section 1 - Official Files:

The Official Personnel Files of all employees shall be maintained in the Office of Human Resources (OHR).

Section 2 - Right to Examine:

Each employee shall have the right to examine the contents of his/her personnel files. Employees shall schedule such reviews with their immediate supervisor and appropriate OHR authority within a reasonable period of time of the employee's request.

Section 3 - Right to Respond:

Each employee shall have the right to answer any material filed in his/her personnel files and his/her answer shall be attached to the material to which it relates.

Section 4 - Right to Copy:

An employee may copy any material in his/her personnel files.

Section 5 - Access by Union:

Upon presentation of written authorization by an employee, a Chief Shop Steward or Union paid staff member may examine the employee's personnel files and make copies of material.

Section 6 - Employee to Receive Copies:

The employee shall receive a copy of all material in his/her personnel file in accordance with present OHR practices.

Section 7 - Access by Others:

The Employer shall inform the employee of all requests outside of the normal for information about him/her or from his/her personnel file. The access card signed by all those that have requested and been given access to the employee's file shall be available for review by the employee.

ARTICLE 20

GRIEVANCE PROCEDURE

Section 1 - Definition:

A. A grievance is defined as an alleged violation or misinterpretation of this Agreement.

B. At any step of the grievance procedure, a grievance meeting may be held by mutual agreement of the parties between the Chief Shop Steward for the appropriate CMHS Administration, the grievant, and management representatives. Consistent with Article 6, for any such meeting, the grievant and the Chief Shop Steward shall be given time off from work to participate in the meeting.

C. Days as defined for this article only shall be defined as calendar days excluding holidays.

Section 2 - Procedure:

Step 1. The union or employee shall orally or in writing present the grievance at the level at which the grievable action took place. The employee shall state which Article and section of the contract was allegedly violated. The grievance shall be presented within seven (7) days from the date of the occurrence or when the employee first had knowledge of, or should have known of, the occurrence. The appropriate management official shall attempt to adjust the matter and shall respond to the grievant within seven (7) days after the receipt of the grievance.

Step 2. If the grievance has not been settled, it shall be presented in writing by the employee and/or the Union to the next level supervisor (the Program Manager, Chief Nurse, or, where appropriate, the Division Head) within seven (7) days after the Step 1 response is due. The second level supervisor shall respond in writing within seven (7) days after receipt of the written grievance. The written grievance shall be clearly identified as a grievance submitted under the provisions of this Article, and shall list the contract provision(s) violated, a general description of the incident giving rise to the grievance, the date or approximate date and location of the violation and the remedy sought.

Step 3. If the grievance is still unresolved, it shall be presented in writing by the employee and/or Union to the next level supervisor (Administration Head [Community Based Services, Children and Youth Services, St. Elizabeths Hospital, Forensic Services, Management Services] or designee) within ten (10) days after the Step 2 response is due. The third level supervisor shall respond in writing (with a copy to the Union) within seven (7) days after receipt of the written grievance.

Step 4. If the grievance is still unresolved, it shall be presented by the employee and/or the Union to the Receiver, in writing within ten (10) days after the Step 3 response is due. The Receiver or his/ her designated representative shall respond in writing within ten (10) days after the receipt of the written grievance.

Step 5. If the grievance is still unresolved, the Union may, by U.S. Mail or by hand to the Receiver, with a copy to Labor Relations, requesting arbitration within twenty (20) days after the reply at Step 4 is due. In addition the Union may move the grievance to Arbitration at anytime after 45 days have passed from the date of the initial grievance filed in accordance with Section 3 below.

Section 3:

In order to be a valid grievance, the grievance must meet the filing time limits, be dated, signed by the grievant, list the contract article and section violated, contain a general description of the incident giving rise to the grievance, the date or approximate date and location of the violation, the remedy sought, and a copy filed with the CMHS Division of Employee and Labor Relations.

Section 4 - Who May Grieve:

Either an employee or the Union may raise a grievance, and if raised by the employee, the Union may associate itself therewith at any time if the employee so desires. Whenever the Union shall raise or is associated with a grievance under this procedure, such a grievance shall become the Union's grievance with the Employer. If raised by the Union, the employee may not thereafter raise the grievance him/herself, and if raised by the employee, he/she may not thereafter cause the Union to raise the same grievance independently.

Section 5 - Selection of the Arbitrator:

The arbitration proceeding shall be conducted by an arbitrator selected from the pool of arbitrators created by the Employer and the Union . The Union and the Employer will select from among the arbitrators who have the earliest open dates for a hearing.

Section 6 - Decision of the Arbitrator:

The decision of the arbitrator shall be final and binding on the parties and shall not be inconsistent with the terms of this Agreement. The arbitrator shall be requested to render his/her decision in writing within thirty (30) days after the conclusion of the arbitration

hearing. At the hearing either party may request the arbitrator to make a bench (unwritten, immediate) decision, which the arbitrator may grant at his/her discretion.

Section 7 - Expenses of the Arbitrator:

Expenses for the arbitrator's services and the proceeding shall be borne equally by the Employer and the Union. However, each party shall be responsible for compensating its own representatives and witnesses. If either party desires a record of the arbitration proceedings, it may cause such a recording to be made, providing it pays for the record and makes copies available without charge to the other party and the arbitrator. Either party may prior to the arbitration hearing, declare up to 5 cases per calendar year to be "loser pays" cases.

ARTICLE 21

UNION SECURITY

Section 1:

The terms and conditions of this Agreement shall apply to all employees in the bargaining unit without regard to Union membership.

Section 2 - Dues Check off:

The Employer agrees to deduct Union dues bi-weekly from the pay of employee members upon proper authorization. The employee must complete and sign Form 277 to authorize the withholding. The amount to be deducted shall be certified to the Employer in writing by the appropriate union officials of AFSCME District Council 20 and AFGE Local 383. It is the responsibility of the employee and the Union to bring errors or changes in status to the attention of the Employer. Corrections or changes will be made at the earliest opportunity after notification is received, but in no case will changes be made retroactively. Union dues withholding authorization may be canceled upon written notification to the Union and the Employer within the thirty-(30) day period prior to the anniversary date of this Agreement. When Union dues are canceled, the Employer shall withhold a service fee in accordance with Section 3 of this Article.

Section 3 - Service Fees:

In keeping with the principle that employees who benefit by the Agreement should share in the cost of its administration, the Union shall require that employees who do not pay Union dues shall pay an amount (not to exceed Union dues) that represents the cost of negotiation and/or representation. Such deductions shall be allowed when the Union presents evidence that at least 51% of the employees in the unit are members of the Union.

Section 4 - Cost of Processing:

The Employer shall deduct $.05 per deduction (dues or service fee) per pay period from each employee who has dues or service fees deducted. This amount represents the fair value of the cost to the Employer for performing the service of payroll deduction.

Section 5 - Hold Harmless:

The Union shall indemnify, defend and hold the Employer harmless against any and all claims, demands and other forms of liability that may arise from the operation of this Article. In any case in which a judgment is entered against the Employer as a result of the deduction of dues or other fees, the amount held to be improperly deducted from an employee's pay and actually transferred to the Union by the Employer shall be returned to the Employer or conveyed by the Union to the employee(s), as appropriate.

Section 6:

Payment of dues shall not be a condition of employment.

ARTICLE 22

TRAINING AND CAREER LADDER

Section 1 - Basic Training:

Other than skills necessary to qualify for the position, the Employer agrees to provide each employee with basic training or orientation for the safe and effective performance of his/her job. Such training shall be provided at the Employer's expense and, if possible, during the employee's regular workday. If the employee is required to participate in training outside regular work hours, the employee will be compensated at the overtime or compensatory rate. Continued training shall be within budgetary constraints.

Section 2 - Continued Training Opportunities:

The Employer will encourage and assist employees in obtaining career related training and education outside the Department by collecting and posting current information available on training and educational opportunities. The Employer will inform employees of time or expense assistance the Employer may be able to provide.

Section 3 - Career Ladder:

The parties recognize and endorse the value of employee training and career ladder programs. Both parties subscribe to the principles of providing career development opportunities for employees who demonstrate potential for advancement. The feasibility of upward mobility and training programs for unit employees shall be a proper subject for labor-management meetings. The Employer will take positive steps to identify those employees who deserve favorable consideration for promotion and this will be recorded on the employee's annual performance evaluation.

Section 4 - Experience Verification:

When an institution of higher learning provides credit for on-the-job experience, the Employer will, at the request of the employee, provide pertinent information to verify the employee's experience with the District.

Section 5 - Union-Sponsored Career Advancement Programs:

Management and the Union support the objective of meaningful career advancement for District government workers in the areas of promotion, transfers and filling of vacancies. In keeping with this objective, the Union will investigate and develop programs to enhance opportunities for career advancement, such as: career counseling services; placement of career planning resource materials on-site; correspondence course arrangements with area colleges, universities, vocational and technical schools; and workshops on resume writing and interview skills.

Programs that are developed will be presented and discussed during appropriate labor-management committee meetings for review and consideration.

ARTICLE 23

CONTINUING EDCUATION REIMBURSEMENT

Section 1:

Provided all of the criteria listed below are fulfilled, the Employer, for full-time Career Service employees will:

1. Reimburse employees for tuition costs, up to a maximum amount of $200 per calendar year; and
2. Grant administrative leave for the purpose of attending instructional classes. Such administrative leave will be for the time the class is in session plus reasonable travel time, not to exceed twenty-four (24) hours per calendar year.

Section 2:

Continuing Education Reimbursement criteria is as follows:

1. The program is directly related to the employee's current duties;

2. The program is not offered by CMHS;

3. The employee has completed his/her probationary period and agrees to reimburse the Employer for the tuition amount and administrative leave if his/her employment is terminated within one (1) year of the completion of the program;

4. Written application to the appropriate manager is made at least eight (8) weeks in advance of the beginning of the program prior written approval is obtained from the appropriate manager (which must be provided or rejected within four {4} weeks of application);

5. Proof of satisfactory completion of the program's requirements; and

6. At management's discretion, a determination that attendance will not adversely affect CMHS operational needs.

Section 3:

Provided all of the conditions specified in this Article are met, administrative leave and the amount of reimbursement will be pro-rated for Career Service part-time employees who regularly work 40-79 hours in a pay period.

ARTICLE 24

LEAVE AT THE BIRTH OR ADOPTION OF A CHILD

Employee leave before and following childbirth shall be granted, in accordance with the Family and Medical Leave Act, at the request of the employee. The employee is obligated to advise his/her supervisor substantially in advance of the anticipated leave date except in an emergency situation.

ARTICLE 25

RETIREMENT

Section 1:

The Employer will provide or arrange for counseling for interested employees who are of retirement age.

Section 2:

The counseling will include information on voluntary deductions, benefits, insurance, and assistance in preparing the necessary retirement papers.

ARTICLE 26

EMPLOYEE ASSISTANCE PROGRAM

Section 1:

The Employer will continue to counsel and make appropriate referrals to an employee assistance program which includes counseling and referral services to employees to deal with a variety of needs and problems such as job performance, emotional, family, drug, alcohol, and marital problems.

Section 2:

The parties recognize that alcoholism is a treatable illness and that drug abuse is a treatable health problem, and recognize the values of complying with the Americans with Disabilities Act.

Section 3:

The Employer recognizes the value of Union cooperation and support for the Employee Assistance Program and the need to maintain open lines of communication on the program with the Union. The Union agrees to support the program actively. Meetings between designated representatives of the Employer and the Union may be held at the request of either party as the need arises.

Section 4:

Employer-Union communications will be consistent with applicable confidentiality requirements of the program.

Section 5:

The Employer will provide a point of contact within the Office of Human Resources for the Union.

Section 6:

The employer and the Union will cooperate in increasing the awareness of employees, supervisors, and stewards of the services available through the Employee Assistance Program.

ARTICLE 27

REDUCTION IN FORCE

Section 1:

The Employer agrees to consult in advance with the Union prior to reaching decisions that might lead to reduction in force in the bargaining unit. The Employer further agrees to minimize the effect of such reduction in force on employees and to consult with the Union toward this end.

Section 2:

Reductions in force and appeals will be conducted in accordance with the Comprehensive Merit Personnel Act and other applicable laws and regulations.

Section 3:

Where there has been a misapplication of the applicable RIF procedures, an employee may file a grievance either through the negotiated grievance procedures or OEA procedures. Once an appeal procedure has been selected, this shall be the sole procedure followed. Under no circumstances may an appeal be filed under both procedures.

ARTICLE 28

ACTING PAY

Section 1:

Employees officially detailed, shall receive a completed Form 1. Employees officially detailed to perform the duties of a higher graded position for more than four (4) pay periods in any calendar year shall receive acting pay of the higher graded position. Details for periods of at least one (1) pay period shall count toward the accumulation of the four (4) pay period requirement. The applicable rate of pay will be determined by application of D. C. Government procedures concerning grade and step placement for temporary promotions, and will be effective the first pay period beginning after the qualifying period has passed. An employee on detail to a lower graded position shall maintain the pay for his/her original position. Advance notice will be given to the Union of any detail exceeding one (1) pay period.

Section 2:

This provision shall not apply to training programs.

Section 3:

Issues involving changed or additional duties assigned to an employee, within his/her present position, shall be considered in accordance with position classification procedures.

ARTICLE 29

UNIFORMS

If and when uniforms are required by the Employer, they shall be furnished by the Employer.

ARTICLE 30

CHANGE IN OPERATIONS

Section 1:

In the event of new operational requirements involving the establishment and operation of residential facilities affecting hours, wages, and working conditions of bargaining unit employees, the employer will have the right to make such changes as are required provided the items in Section 2 are followed:

Section 2:

The operational requirements for residential facilities will go into effect as needed however CMHS will immediately bargain over any necessary changes to this contract, using expedited arbitration to resolve any unsettled issues. The arbitrator may award back pay retroactive to the date of the implementation of any new operational requirements, if warranted.

ARTICLE 31

CONTRACTING OUT

Section 1:

It is recqgnized that contracting out of work that is normally performed by employees covered by this Agreement is of mutual concern to the CMHS and the Union. Decisions

regarding contracting out are areas of discretion of the CMHS or higher authority. However, the CMHS agrees to consult with the Union 60 days prior to final action, except in emergencies, regarding the impact of such contracting out on employees covered by this Agreement.

ARTICLE 32

ADMINISTRATIVE CLOSINGS

Section 1:

Essential employees required to work when all other CMHS employees are released due to an Administrative Closing shall be compensated at the appropriate rate (i.e., straight-time or over-40 hours worked compensation) in accordance with the minimum standards established by the FLSA.

Section 2:

Essential employees required to work when all other CMHS employees are released due to an Administrative Closing shall earn compensatory time on an hour for hour basis for the shift for which an Administrative Closing has been declared. Administrative Closings are determined by the Employer and may be declared to address such situations that affect all employees (for example, when weather conditions make travel unduly hazardous) but would not include localized conditions (such as a power outage affecting a work area).

CMHS shall identify essential positions. Each essential employee shall be notified of the essential status of his/her position.

Section 3:

Employees not designated as essential shall receive compensatory time on an hour for hour basis for work performed on their regularly scheduled tour of duty when all other employees on the same tour of duty in the same work unit are not required to work due to the declaration of an Administrative Closing.

ARTICLE 33

Employee Job Performance, Appraisals, Productivity, and Gainsharing

Section 1:

The Parties recognize the importance and relationship between employee job performance, performance appraisals, and productivity. As such each employee shall receive an annual performance appraisal, as well as oral and/or written feedback during the year of the performance appraisal. Employees shall not be disciplined for on-going performance failures without feedback from the evaluator through counseling, instructions or mandatory in service training in order for the employee to meet performance standards. Employees whose performance is less than satisfactory shall be so notified not less than ninety (90) days prior to the end of the performance rating period. Employees shall receive a step increase provided they have a "Satisfactory" (or equivalent) performance appraisal.

Section 2:

The parties agree to create a committee of an equal number of Employer and Union representatives to study, develop, and if mutually agreed, establish gainsharing programs where groups of employees will share in (in the form of additional compensation) specific delivery of service advancements and other productivity gains.

ARTICLE 34

SAVINGS CLAUSE

Section 1:

Should any provision of this Agreement be rendered or declared invalid by reason of any existing or subsequently enacted legislation or by decree of a court or administrative agency of competent jurisdiction, such invalidation shall not affect any other part or provision hereof. In that event, either party shall have the right to demand negotiations for a substitute provision.

ARTICLE 35

EFFECTIVE DATE, DURATION, AND AMENDMENT

Section 1:

This Agreement shall be in full force and effect from the date of approval through September 30, 2001 or until a successor contract is negotiated.

Section 2:

This Agreement constitutes the sole and entire Agreement between the parties, who do mutually waive the right to negotiate on any further subject during the life of this Agreement, except by mutual consent.

FOR THE COMMISSION ON MENTAL HEALTH SERVICES:

FOR THE UNION:

ADDENDUM

The following is for informational purposes only and was not negotiated:

A. ANNUAL LEAVE:

Employees shall earn annual leave from the date of hire if the appointment is for ninety (90) days or longer. Employees shall be eligible to take vacation (annual leave) as of the first day of employment if the appointment is for ninety (90) days or longer.

Annual leave may be accrued; however, no more than thirty (30) days annual leave may be carried forward into the next leave year unless any of the following conditions are met;

a) To correct an administrative error.

b) When annual leave was scheduled in advance but its use denied because of exigencies of public business.

c) When the annual leave was scheduled in advance but its use was precluded because of illness or injury.

If, at the end of any leave year, an employee has annual leave in excess of the normal permissible annual leave carryover because of one or more of the above reasons, he shall not forfeit the excess. All restored annual leave must be taken within two (2) years from the date of restoration. It is understood that all decisions relating to this matter are within the authority of the Receiver for CMHS.

B. FUNERAL LEAVE:

In the event of a death in the immediate family (parent, sister, brother, spouse, child, mother-in-law, sister-in-law, brother-in-law, son-in-law, or daughter-in-law) of any employee every effort will be made to grant annual leave.

C. MILITARY FURLOUGH;

An employee who enlists or is ordered to active duty in the Armed Forces can claim restoration rights within ninety (90) days of release from active duty under honorable conditions.

The Department shall restore an eligible employee as soon as possible after he/she applies, but in any case he/she shall be restored within thirty (30) days after the Department receives his/her application.

D. ANNUAL LEAVE – ACCUMULATION:

Annual leave will be earned as follows (based on full-time employment in a pay status):

1) Less than three years service – four hours each pay period;
2) More than three years service, but less than fifteen years of service – six hours each pay period; and
3) More than fifteen years service – eight hours each pay period.

E. SICK LEAVE:

Employees shall start to earn sick leave from their date of hire, at the rate of one-half day each bi-weekly pay period, and shall accumulate sick leave as long as they are in the service of the employer.

Employees shall be credited for unused sick leave by having such leave for employees who terminate employment other than by retirement shall remain to his/her credit for three years.

F. FUNERAL LEAVE:

Funeral leave not to exceed three (3) work days shall be granted to an employee in connection with the funeral of, or memorial services for his/her immediate relative who dies as a result of wounds, disease, or injury incurred while serving as a member of the Armed Forces in a combat zone, in accordance with Section 1203 (n) of the Comprehensive Merit Personnel Act.

G. HOLIDAYS:

The District of Columbia Government Comprehensive Merit Personnel Act prescribe the procedures for legal holidays for employees of the District Government:

1) New Years Day, January 1;
2) Dr. Martin Luther King, Jr.'s Birthday, the third Monday in January;
3) President's Day, the third Monday in February;
4) Memorial Day, the last Monday in May;
5) Independence Day, July 4;
6) Labor Day, the first Monday in September;
7) Columbus Day, the second Monday in October;
8) Veterans' Day, November 11;
9) Thanksgiving Day, the fourth Thursday in November; and
10) Christmas Day, December 25.

DEPARTMENT OF MENTAL HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Mental Health, pursuant to the authority set forth in section 14 of the District of Columbia Department of Mental Health Establishment Congressional Review Emergency Amendment Act of 2001, effective July 23, 2001 (D.C. Act 14-101) ("Act"), hereby gives notice of the adoption of the following new Chapter 34, of Title 22 of the D.C. Code of Municipal Regulations, entitled Mental Health Rehabilitation Services Provider Certification Standards. Chapter 34, Title 22, DCMR sets forth the rules that the Department of Mental Health shall use to certify community-based providers of mental health rehabilitation services and implement the Medicaid Rehabilitation Option for mental health rehabilitation services.

Notice of Proposed Rulemaking was published on July 27, 2001, at 48 DCR 6902. These final rules will be (or were) effective on November 9, 2001.

Title 22 DCMR is amended by adding the following new Chapter 34:

MENTAL HEALTH REHABILITATION SERVICES PROVIDER CERTIFICATION STANDARDS

3400 GENERAL PROVISIONS

3400.1 The Department of Mental Health entered into a Memorandum of Agreement with the Department of Health, Medical Assistance Administration to implement a Medicaid Rehabilitation Option for the provision of mental health rehabilitative services.

3400.2 Each DMH-certified MHRS provider shall meet and adhere to the terms and conditions of its Human Care Agreement with DMH and its Medicaid provider agreement with MAA.

3401 MHRS PROVIDER CERTIFICATION PROCESS

3401.1 Each applicant seeking certification as an MHRS provider shall submit a certification application to DMH. A DMH-certified MHRS provider seeking renewal of certification shall submit a certification application at least ninety (90) days prior to the termination of its current certification.

3401.2 Upon receipt of a certification application, DMH shall review the certification application to determine if it is complete. If a certification application is incomplete, DMH shall return the incomplete certification application to the applicant. An incomplete certification application shall not be regarded as a certification application, and return of the incomplete certification application and DMH's failure to take further action to issue certification to the applicant shall not constitute denial of an application for certification or renewal of certification.

Exhibit #2

3401.3 Following DMH's acceptance of the certification application, DMH shall determine whether the applicant's services and activities meet the certification standards described in this Chapter. DMH shall schedule and conduct an on-site survey of the applicant's services to determine whether the applicant satisfies all the certification standards.

3401.4 DMH may conduct an on-site survey at the time of certification application or certification renewal, or at any other time with appropriate notice, and shall have access to all records necessary to verify compliance with certification standards, and may conduct interviews with staff, others in the community, and consumers with consumer permission.

3401.5 DMH shall issue certification to each applicant complying with the certification standards. DMH shall issue certification to each DMH-certified MHRS provider seeking renewal of certification that complies with the certification standards.

3401.6 An applicant or DMH-certified MHRS provider that fails to comply with the certification standards shall receive a written statement of non-compliance from DMH within thirty (30) working days, after the conclusion of the on-site survey. The written statement of non-compliance shall describe the areas of non-compliance, suggest actions needed to bring the applicant's operations into compliance with the standards, and set forth a timeframe for the applicant to submit a written plan of correction.

3401.7 An applicant or DMH-certified MHRS provider's written plan of correction shall describe the actions to be taken and specify a timeframe for correcting the areas of non-compliance with the certification standards. The written plan of correction shall be submitted to DMH within ten (10) working days after receipt of the written statement of non-compliance from DMH.

3401.8 DMH shall notify the applicant or DMH-certified MHRS provider whether the provider's plan of correction is accepted within five (5) working days after receipt of the written plan of correction.

3401.9 DMH shall issue certification after DMH verifies that the applicant or DMH-certified MHRS provider has complied with its written plan of correction and meets all the certification standards.

3401.10 If a DMH-certified MHRS provider adds an MHRS service during the term of certification, the MHRS provider shall submit a certification application describing the service. Upon determination by DMH that the service is in compliance with certification standards, DMH shall certify the MHRS provider to provide that service.

3401.11 Certification as an MHRS provider shall be two calendar years from the date of issuance of certification by DMH, subject to the MHRS provider's continuous compliance with these certification standards. Certification shall remain in effect

until it expires, is renewed or revoked. Certification shall specify the effective date of the certification, whether the MHRS provider is certified as a CSA, subprovider or specialty provider, and the types of services the MHRS provider is certified to provide.

3401.12 Certification is not transferable to any other organization.

3401.13 The MHRS provider shall notify DMH immediately of any changes in its operation that affect the MHRS provider's continued compliance with these certification standards, including changes in ownership or control, changes in service and changes in its affiliation and referral arrangements.

3401.14 The Director may deny or revoke certification if the applicant or MHRS provider fails to comply with any certification standard.

3401.15 Certification shall be considered terminated and invalid if the MHRS provider fails to apply for renewal of certification prior to the expiration date of the certification, voluntarily relinquishes certification, or goes out of business.

3402 SERVICE COVERAGE

3402.1 MHRS are those rehabilitative or palliative services administered by DMH and rendered by DMH-certified MHRS providers to eligible consumers who require such services.

3402.2 MHRS are intended for the maximum reduction of mental disability and restoration of a consumer to his or her best possible functional level.

3402.3 MHRS are recommended by a physician or a licensed practitioner of the healing arts and rendered by practitioners and clinicians (qualified practitioners) and credentialed staff, under the supervision of qualified practitioners, in certified community mental health rehabilitation services agencies in accordance with the certification standards established in this Chapter.

3402.4 Rehabilitative services covered as MHRS are:

(a) Diagnostic/Assessment;

(b) Medication/Somatic Treatment;

(c) Counseling and Psychotherapy;

(d) Community Support;

(e) Crisis/Emergency;

(f) Rehabilitation;

(g) Intensive Day Treatment;

(h) CBI; and

(i) ACT.

3402.5 Eligible consumers of MHRS shall meet eligibility requirements established in §3403.

3402.6 Eligible MHRS providers include CSAs, subproviders, and specialty providers that are certified in compliance with the certification standards set forth in this Chapter.

3402.7 Qualified practitioners rendering MHRS through DMH-certified MHRS providers shall meet eligibility requirements described in §3413.

3402.8 MHRS coverage limitations are set forth in §3424. Coverage for any MHRS is contingent on whether all of the following criteria are met:

(a) The service shall be medically necessary;

(b) The service shall be delivered by a DMH-certified MHRS provider as described in §3410, §3411 and §3412;

(c) The service shall be delivered by qualified practitioners (and credentialed staff under the supervision of qualified practitioners) acting within their scope of practice as identified in §3413;

(d) The service shall be delivered in accordance with an approved IRP/IPC as described in §3407, §3408 and §3409; and

(e) The service shall be delivered in accordance with the service specific standards set forth in §3414, §3415, §3416, §3417, §3418, §3419, §3420, §3421, §3422 and §3423.

3402.9 All consumers receiving MHRS shall have free choice of MHRS providers and free choice of qualified practitioners delivering services through a DMH-certified MHRS provider, as described in §3406.

3402.10 All consumers receiving MHRS shall have the right to file a grievance with DMH and shall receive fair hearing rights and notice of such rights in accordance with processes established by DMH.

3403 ELIGIBLE CONSUMERS

3403.1 Eligible consumers of MHRS include children and youth with mental health problems and adults with mental illness as described in the District of Columbia

Department of Mental Health Establishment Congressional Review Emergency Amendment Act of 2001 (D.C. Act 14-101), certified as requiring MHRS by a qualified practitioner.

3403.2 Eligible consumers of MHRS shall have a primary diagnosis on either Axis 1 or 2 of the DSM-IV.

3403.3 Persons with a primary substance abuse diagnosis only are not eligible consumers of MHRS.

3404 AUTHORIZATION AND RE-AUTHORIZATION OF MHRS

3404.1 Most MHRS do not require prior authorization by DMH, although some require re-authorization after specified amounts of services have been delivered. Prior authorization and re-authorization requirements are described in §3424.

3404.2 For services requiring either prior authorization or re-authorization under §3424, the CSA shall submit a Rehabilitation Services Treatment Request Form to DMH for review and approval.

3404.3 Upon receiving the Rehabilitation Services Treatment Request Form, DMH shall determine whether MHRS are medically necessary and issue a service authorization decision to the CSA.

3404.4 As part of the service authorization process, DMH may review the consumer's IRP/IPC or other clinical material if additional clinical information is required in order to evaluate consumer needs and make a level of care determination.

3405 CONSUMER PROTECTIONS

3405.1 Each MHRS provider shall have a statement of consumer rights and responsibilities authorized by its governing authority (Consumer Rights Statement). The Consumer Rights Statement shall be:

(a) Consistent with federal and District laws and regulations; and

(b) Posted in strategic and conspicuous areas to maximize consumer, family and staff awareness.

3405.2 Each MHRS provider shall establish and adhere to a system for distributing the Consumer Rights Statement which ensures that all consumers receive the Consumer Rights Statement during the intake process. Each MHRS provider shall document that the Consumer Rights Statement is distributed to all consumers.

3405.3 Each MHRS provider shall establish and adhere to a well-publicized complaint and grievance system, which includes written policies and procedures for handling consumer, family, and practitioner complaints and grievances

(Complaint and Grievance Policy). Each MHRS provider's Complaint and Grievance Policy shall:

(a) Comply with applicable federal and District laws and regulations;

(b) Require the MHRS provider to document distribution of information about the Complaint and Grievance Policy to all consumers, staff and qualified practitioners; and

(c) Contain mechanisms to address complaints relating to beliefs, values, and other cultural norms.

3405.4 Each MHRS provider shall establish and adhere to policies and procedures for obtaining written informed consent to treatment from consumers (Consent to Treatment Policy) which comply with applicable federal and District laws and regulations.

3405.5 Each MHRS provider shall establish and adhere to policies and procedures governing the release of mental health information about consumers (Release of Consumer Information Policy), which comply with applicable federal and District laws and regulations. For consumers with co-occurring psychiatric and addictive disorders, the MHRS provider shall comply with the requirements of 42 CFR Part II governing the confidentiality and release of drug and alcohol treatment records.

3405.6 Each MHRS provider shall establish and adhere to policies and procedures governing the use of advance instructions for mental health treatment, durable power of attorney for health care and advance directives that comply with applicable federal and District laws and regulations (Advance Instructions Policy).

3405.7 Each MHRS provider's Advance Instructions Policy shall require qualified practitioners to incorporate the development of advance instructions for mental health treatment, durable power of attorney for health care, and advance directives into the IRP/IPC planning process.

3405.8 DMH shall review and approve each MHRS provider's Consumer Rights Statement, Complaint and Grievance Policy, Consent to Treatment Policy, Release of Consumer Information Policy and Advance Instructions Policy, during the certification process.

3406 **CONSUMER CHOICE**

3406.1 Each MHRS provider shall establish and adhere to policies and procedures governing the means by which consumers shall be informed of the full choices of MHRS providers, qualified practitioners and other mental health service providers available, including information about peer support and family support services and groups and how to access these services (MH Consumer Choice Policy).

3406.2 DMH shall review and approve each MHRS provider's MH Consumer Choice Policy during the certification process.

3406.3 The MH Consumer Choice Policy shall comply with applicable federal and District laws and regulations.

3406.4 Each MHRS provider shall make its MH Consumer Choice Policy available to consumers and their families and shall establish and adhere to a system for documenting that consumers and families receive the MH Consumer Choice Policy.

3406.5 Each CSA's MH Consumer Choice Policy shall ensure that each enrolled consumer:

(a) Requesting MHRS directly from the CSA is informed that the consumer may choose to have MHRS provided by any of the other DMH-certified CSAs;

(b) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the DMH-certified subproviders that have entered into affiliation agreements with that CSA;

(c) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the qualified practitioners employed by or contracted by the CSA to provide MHRS, including qualified practitioners providing MHRS through one of the CSA's subcontractors; and

(d) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the DMH-certified specialty providers that have entered into affiliation agreements with that CSA.

3406.6 Each subprovider's MH Consumer Choice Policy shall ensure that each consumer:

(a) Enrolled in a CSA requesting MHRS directly from the subprovider is directed to that CSA for Diagnostic/Assessment and IRP/IPC development and approval;

(b) Not enrolled in a CSA and requesting MHRS directly from the subprovider is directed to DMH's Consumer Enrollment and Referral System; and

(c) Enrolled in a CSA and referred by that CSA to the subprovider for MHRS is informed that the consumer may choose to have MHRS provided by any of the qualified practitioners employed by or contracted by the subprovider to provide MHRS, including the subprovider's subcontractors.

3406.7 Each specialty provider's MH Consumer Choice Policy shall ensure that each consumer:

(a) Enrolled in a CSA requesting MHRS directly from the specialty provider is directed to that CSA for Diagnostic/Assessment and IRP/IPC development and approval;

(b) Not enrolled in a CSA and requesting MHRS directly from the specialty provider is directed to DMH's Consumer Enrollment and Referral System; and

(c) Enrolled in a CSA and referred by that CSA to the specialty provider for MHRS is informed that the consumer may choose to have MHRS provided by any of the qualified practitioners employed by or contracted by the specialty provider to provide MHRS, including the specialty provider's subcontractors.

3407 TREATMENT PLANNING PROCESS

3407.1 Each CSA shall coordinate the treatment planning process for its enrolled consumers.

3407.2 The treatment planning process for consumers shall, at a minimum, include:

(a) The completion of a Diagnostic/Assessment service and required components as described in §3415;

(b) Development of an IRP/IPC as described in §3408;

(c) Development of an ISSP by each subprovider providing Medication/Somatic Treatment, Counseling and Psychotherapy or Community Support to the consumer as described in §3409 and required by the IRP/IPC;

(d) Development of an ISSP by each specialty provider providing Rehabilitation, Intensive Day Treatment, CBI or ACT to the consumer as described in §3409 and required by the IRP/IPC; and

(e) Consideration of the consumer's beliefs, values and cultural norms in how, what and by whom MHRS are to be provided.

3407.3 Court-appointed guardians for adults, children and youth and the parents or family members of children and youth shall be involved in the treatment planning process. The families and significant others of adult consumers may participate in the treatment planning process to the extent that the adult consumer consents to the involvement of family and significant others.

3408 IRP/IPC DEVELOPMENT AND IMPLEMENTATION

3408.1 Except where pre-authorized or authorized under §3424, the IRP/IPC shall serve as authorization for the provision of MHRS and for the development of any ISSP required by the IRP/IPC.

3408.2 The IRP/IPC shall serve as certification that the MHRS are medically necessary as indicated by the approving practitioner's signature on the initial and subsequent IRP/IPC. The approving practitioner's approval of an IRP/IPC shall occur by the fourth visit or within thirty (30) calendar days after the consumer enrolls with the CSA, whichever occurs first.

3408.3 Each CSA shall develop and maintain a complete and current IRP/IPC for each enrolled consumer.

3408.4 Development of the IRP/IPC shall commence after the first clinical contact with the consumer, so that payment may be made for MHRS delivered consistent with the initial IRP/IPC. Consumers in a crisis situation who are eligible for ACT, CBI or Crisis/Emergency shall receive such services while the IRP/IPC is being developed.

3408.5 The IRP/IPC shall include the following elements:

(a) A description of the consumer's strengths or assets and challenges and how the consumer's strengths and assets will be utilized in achieving treatment goals.

(b) A statement of the mutually desired overall long-term results of each intervention, intermediate steps to be taken to achieve those long-term results and the overall treatment being provided for the consumer (Treatment Goals). Treatment Goals shall be based on the consumer's expressed needs and needs identified through Diagnostic/Assessment services, and referral information.

(c) A statement of the specific consumer or family skills that need to be developed or improved. This statement shall identify services and resources that need to be changed or modified to achieve each Treatment Goal (Objectives). Objectives shall be stated in terms of attainable and measurable results.

(d) A description of the interventions to be used to achieve each Objective and Treatment Goal including, but not limited to:

(1) A staff position or service component responsible for the intervention;

(2) The names of other agencies (and other human services systems if applicable) providing services for the consumer, a description of

the service being provided, identification by name and title of the staff persons of those agencies or systems of care responsible for providing such services, and evidence of interagency service coordination;

(3) The intervention by service type, with the IRP/IPC identifying all services related to the provision of mental health services, regardless of the payment source for the service;

(4) The frequency and duration of the interventions;

(5) For each service, the MHRS provider chosen by the consumer; and

(6) A plan for addressing any medical problems that significantly impact or could be expected to affect the consumer's functioning which is to be carried out by either the CSA or another health-providing organization or practitioner.

(e) Development of psychiatric advance instructions, advance directives, crisis prevention plan, and relapse prevention plan.

3408.6 The clinical manager shall discuss the IRP/IPC with the consumer on an ongoing basis.

3408.7 Specific information describing the consumer's response to, participation in and agreement to the IRP/IPC shall be recorded in the consumer's clinical record.

3408.8 The clinical manager shall document the consumer's participation in the development of the IRP/IPC by obtaining the consumer's signature on the IRP/IPC, and documenting the consumer's own words used to communicate with the Diagnostic/Assessment Team. A court-appointed guardian for adults, children and youth and the parent or family member of children and youth consumers may sign the IRP/IPC, if required by District laws and regulations.

3408.9 In situations where the consumer does not demonstrate the capacity to sign or does not sign the IRP/IPC, the reasons the consumer does not sign shall be recorded in the consumer's clinical record, including each date where signature was attempted.

3408.10 The approving practitioner and the clinical manager shall sign the IRP/IPC.

3408.11 The clinical manager has an affirmative obligation to ask the consumer to document participation and agreement with the IRP/IPC at each subsequent encounter if the consumer did not sign the IRP/IPC.

3408.12 Documentation of participation of the consumer's court-appointed guardian, family and significant others in the development of the IRP/IPC shall also be included in the consumer's clinical record, as appropriate.

3408.13 Each MHRS provider shall develop policies and procedures for IRP/IPC review (IRP/IPC Review Policy). The IRP/IPC Review Policy shall be part of the MHRS provider's Treatment Planning Policy as required by §3410.12.

3408.14 The IRP/IPC Review Policy shall require that the IRP/IPC be reviewed and updated every ninety (90) days and any time there is a significant change in the consumer's condition or situation to reflect progress toward or the lack of progress toward the Treatment Goals. The IRP/IPC may be reviewed more frequently, as necessary, based on the consumer's progress or circumstances.

3408.15 Each IRP/IPC review shall include a review of each of the items stated in §3408.5 including progress on Treatment Goals, re-identification of strengths and progress on Objectives.

3408.16 The consumer, the consumer's clinical manager, approving practitioner and other qualified practitioners as necessary or appropriate shall establish new Objectives and modify, add or delete Treatment Goals based on the results of the IRP/IPC review, the consumer's assessment of progress toward meeting Treatment Goals and any new needs, and any other assessments provided by significant others, family or other professionals.

3408.17 At least the approving practitioner and the consumer shall participate in the IRP/IPC review.

3408.18 At the IRP/IPC review, the approving practitioner shall identify all required MHRS re-authorizations and establish a target date for requesting the re-authorizations well in advance of their expiration dates.

3408.19 The approving practitioner shall document the consumer's participation in the IRP/IPC review by obtaining the consumer's signature on the revised IRP/IPC. A court-appointed guardian for adults, children and youth and the parent or family member of children and youth consumers may be required to sign the revised IRP/IPC, if required by District laws and regulations.

3408.20 Documentation of participation of the consumer's court-appointed guardian, family and significant others in the review of the IRP/IPC shall also be included in the consumer's clinical record, as appropriate.

3409 ISSP DEVELOPMENT AND IMPLEMENTATION

3409.1 An ISSP shall be developed by each subprovider providing Medication/Somatic Treatment, Counseling and Psychotherapy, or Community Support to the consumer, and by each specialty provider providing Rehabilitation, Intensive Day Treatment, CBI, or ACT if the IRP/IPC requires the consumer receive such service. The ISSP shall be developed within the time specified in the rules governing the specific service.

3409.2 The ISSP shall identify each service intervention and specify the service amount, duration, scope, and frequency consistent with the consumer's IRP/IPC. The ISSP shall describe Treatment Goals, Objectives, and interventions to be used to achieve Treatment Goals and Objectives and the methods for determining effectiveness of the ISSP.

3409.3 Specific information describing the consumer's response to, participation in, and agreement to the ISSP shall be recorded.

3409.4 The subprovider or specialty provider shall document the consumer's participation in the development of the ISSP by obtaining the consumer's signature on the ISSP and documenting of consumer's own words used to communicate with the Diagnostic/Assessment Team. A court-appointed guardian for adults, children and youth and the parent or family member of children and youth consumers may be required to sign the ISSP, if required by District laws and regulations.

3409.5 In situations where the consumer does not demonstrate the capacity to sign or does not sign the ISSP, the reasons the consumer does not sign shall be recorded in the consumer's clinical record, including each date where signature was attempted.

3409.6 The approving practitioner has an affirmative obligation to ask the consumer to document participation and agreement with the ISSP at each subsequent encounter if the consumer did not sign the ISSP.

3409.7 Documentation of participation of the consumer's court-appointed guardian, family and significant others in the development of the ISSP shall also be included in the consumer's clinical record, as appropriate.

3409.8 Each subprovider providing Medication/Somatic Treatment, Counseling and Psychotherapy, or Community Support, and each specialty provider providing Rehabilitation, Intensive Day Treatment, CBI, or ACT shall develop policies and procedures for the ISSP review (ISSP Review Policy). The ISSP Review Policy shall be part of the subprovider or specialty provider's Treatment Planning Policy as required by §3410.12.

3409.9 The ISSP Review Policy shall require that review of each ISSP for a consumer occurs concurrently with the IRP/IPC review. At a minimum, the ISSP review shall occur every ninety (90) days and the ISSP Review Policy shall require that the ISSP review demonstrate how the ISSP is used to modify or change Treatment Goals, Objectives and interventions, consistent with the IRP/IPC.

3410 MHRS PROVIDER QUALIFICATIONS – GENERAL

3410.1 Each MHRS provider shall be established as a legally recognized entity in the United States and qualified to conduct business in the District. A certificate of

good standing issued by the District of Columbia Department of Consumer and Regulatory Affairs shall be evidence of qualification to conduct business.

3410.2 Each MHRS provider shall maintain the clinical operations policies and procedures described in this section which shall be reviewed and approved by DMH, during the certification survey process.

3410.3 Each MHRS provider shall:

(a) Have a governing authority, which shall have overall responsibility for the functioning of the MHRS provider;

(b) Comply with all applicable federal and District laws and regulations;

(c) Hire personnel with the qualifications necessary to provide MHRS and to meet the needs of its enrolled consumers;

(d) Ensure that qualified practitioners, listed in §3413, are available to provide appropriate and adequate supervision of all clinical activities; and

(e) Employ qualified practitioners that meet all professional requirements as defined by the District's licensing laws and regulations relating to the profession of the qualified practitioner.

3410.4 Each MHRS provider shall establish and adhere to policies and procedures for selecting and hiring staff (Staff Selection Policy), including, but not limited to requiring:

(a) Evidence of licensure, certification or registration as applicable and as required by the job being performed;

(b) For unlicensed staff, evidence of completion of an appropriate degree, training program, or credentials, such as academic transcripts or a copy of degree;

(c) Appropriate reference and background checks;

(d) Evidence of completion of all communicable disease testing required by District laws and regulations, including a Tuberculin skin test or a chest x-ray and a Hepatitis B test;

(e) A process by which all staff, as a condition of hiring, shall:

(1) Declare any past events which might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations;

(2) Indicate whether they are presently using illegal drugs; and

(3) Attest that they are capable of performing the essential functions of their jobs, with or without accommodation; and

(f) A mechanism for ongoing monitoring of staff licensure, certification, or registration, such as an annual confirmation process concurrent with staff performance evaluations which includes repeats of screening checks outlined above as appropriate.

3410.5 Each MHRS provider shall establish and adhere to written job descriptions for all positions, including, at a minimum, the role, responsibilities, reporting relationships, and minimum qualifications for each position. The minimum qualifications for each position shall be appropriate for the scope of responsibility and clinical practice described for each position.

3410.6 Each MHRS provider shall establish and adhere to policies and procedures requiring a periodic evaluation of clinical and administrative staff performance (Performance Review Policy) that require an assessment of clinical competence, as well as general organizational work requirements, and an assessment of key functions as described in the job description.

3410.7 Each MHRS provider shall establish and adhere to policies and procedures to ensure that clinical staff are licensed and to the extent required by applicable District laws and regulations, work under the supervision of a qualified practitioner (Supervision and Peer Review Policy). The Supervision and Peer Review Policy shall:

(a) Include procedures for clinical supervision, which require sufficient clinical supervision conducted by qualified practitioners;

(b) Require personnel files of non-licensed clinical staff and consumer clinical records to contain evidence that the Supervision and Peer Review Policy is observed; and

(c) Include an active peer review process to monitor quality of care delivered by qualified practitioners and credentialed staff.

3410.8 Each MHRS provider shall establish and adhere to policies and procedures governing the credentialing or privileging of staff (Credentialing Policy) consistent with DMH rules on privileging and competency-based credentialing systems. The Credentialing Policy shall:

(a) Allow staff who do not possess college degrees to be credentialed for direct service work, based on educational equivalent qualifications which include experience that provides an individual with an understanding of mental illness and which was acquired as an adult through personal experience with the mental health treatment system and recovery or

through the provision of significant supports to adults with mental illness or children and youth with mental health problems and with serious emotional disturbance;

(b) Facilitate the employment of persons in recovery as peer counselors and members of community support teams; and

(c) Include an assessment of qualified practitioners' cultural competence.

3410.9 Each MHRS provider shall provide training to all staff, including all qualified practitioners (both those employed and those under contract to the MHRS provider), as orientation to MHRS (Staff Orientation Training) during the first three (3) months of employment and on an ongoing basis. The Staff Orientation Training curriculum shall address the following:

(a) Mental illnesses and evidence-based clinical interventions;

(b) Consumer rights;

(c) Declaration of advance instructions for mental health treatment, durable power of attorney for health care, and advance directives;

(d) Definitions and types of abuse and neglect and the MHRS provider's policies on investigating allegations of abuse and neglect;

(e) Recovery model, psychiatric rehabilitation, consumer and family empowerment, and self-help or peer support;

(f) Knowledge of medication, its benefits, and side effects;

(g) Child-centered, family-focused, and multi-system service delivery;

(h) Communication skills;

(i) Integrated treatment for co-occurring psychiatric and addictive disorders;

(j) Behavior management;

(k) Handling emergency situations;

(l) Recordkeeping and clinical documentation standards;

(m) Confidentiality;

(n) DMH Consumer Enrollment and Referral System;

(o) MHRS provider's policies and procedures;

(p) Medicaid MHRS requirements, especially those relating to recordkeeping, billing, documentation, and consumer choice; and

(q) Cultural competence and its relationship to treatment outcomes.

3410.10 Each MHRS provider shall establish and adhere to an annual training plan for staff to ensure that all staff receive at a minimum, annual training on the following topics (Annual Training Plan):

(a) The subjects covered during Staff Orientation Training;

(b) Infection control guidelines, including compliance with the bloodborne pathogens standard, communicable diseases and universal precautions;

(c) Safety and risk management; and

(d) The MHRS provider's Disaster Evacuation Plan.

3410.11 Each MHRS provider shall establish and adhere to policies and procedures defining pre-admission, intake, screening, referral, transfer, and discharge procedures (Admission, Transfer, and Discharge Policy) that comply with applicable federal and District laws and regulations.

3410.12 Each MHRS provider shall establish and adhere to policies and procedures governing the coordination of the treatment planning process (Treatment Planning Policy), including procedures for designing, implementing, reviewing, and revising each consumer's IRP/IPC and ISSPs that comply with the requirements of §3407, §3408 and §3409.

3410.13 Each MHRS provider shall establish and adhere to policies and procedures requiring that treatment be provided in accordance with the service specific standards in §3414, §3415, §3416, §3417, §3418, §3419, §3420, §3421 and §3422 (Service Specific Policy). The Service Specific Policy shall:

(a) Address supervision requirements and required caseload ratios that are appropriate to the population served and treatment modalities employed; and

(b) Include a written description of the services offered by the MHRS provider (Service Description) describing the purpose of the service, the hours of operation, the intended population to be served, treatment modalities provided by the service, treatment objectives, and expected outcomes.

3410.14 Each MHRS provider shall establish and adhere to policies and procedures governing communication with the consumer's primary care providers (Primary Care Provider Communication Policy). The Primary Care Provider Communication Policy shall:

(a) Require the MHRS provider to obtain and document authorization from the consumer in the consumer's clinical records before contacting the consumer's primary care providers;

(b) Outline the MHRS provider's interface with primary health care providers, managed health care plans, and other providers of mental health services; and

(c) Describe the MHRS provider's activities which will enhance consumer access to primary health care and the coordination of mental health and primary health care services.

3410.15 Each MHRS provider shall establish and adhere to policies and procedures for handling routine, urgent, and emergency situations (Unscheduled Service Access Policy). The Unscheduled Service Access Policy shall:

(a) Include referral procedures to local emergency departments;

(b) Include staff assignment to cover emergency walk-in hours;

(c) Include on-call arrangements for clinical staff and physicians;

(d) Cover the interface with the DMH-designated crisis and emergency service; and

(e) Include procedures for triaging consumers who require Crisis/Emergency services or psychiatric hospitalization.

3410.16 Each MHRS provider shall establish and adhere to policies and procedures for clinical record documentation, security, and confidentiality of consumer and family information, clinical records retention, maintenance, purging and destruction, and for disclosure of consumer and family information, and informed consent that comply with applicable federal and District laws and regulations (Clinical Records Policy). The Clinical Records Policy shall:

(a) Require the MHRS provider to maintain all clinical records in a secured and locked storage area;

(b) Require the MHRS provider to maintain and secure a current, clear, organized, and comprehensive clinical record for every individual assessed, treated, or served which includes information deemed necessary to provide treatment, protect the MHRS provider, or comply with applicable federal and District laws and regulations; and

(c) Require that the clinical record contain information to identify the consumer, support the diagnosis, justify the treatment, document the course and results of treatment, and facilitate continuity of care. The clinical record shall include, at a minimum:

(1) Consumer identification information, including enrollment information;

(2) Identification of a person to be contacted in the event of emergency;

(3) Basic screening and intake information;

(4) Documentation of internal or external referrals;

(5) Comprehensive diagnostic and psychosocial assessments;

(6) Pertinent medical information including the name, address, and telephone number of the consumer's primary care physician and the name and address of the consumer's preferred hospital;

(7) Advance instructions and advance directives;

(8) The IRP/IPC and ISSP as appropriate;

(9) For children and youth, documentation of family involvement in treatment planning and services or statement of reasons why it is not clinically indicated;

(10) Methods for addressing consumers' and families' special needs, especially those which relate to communication, cultural, and social factors;

(11) Detailed description of services provided;

(12) Progress notes;

(13) Discharge planning information;

(14) Appropriate consents for service;

(15) Appropriate release of information forms; and

(16) Signed Consumer Rights Statement.

3410.17 Progress notes shall:

(a) Be written at least once per month and as needed;

(b) Reflect IRP/IPC and ISSP implementation, including documentation of the choices and perceptions of the consumer regarding the service(s) provided; and

(c) Be signed and dated by the credentialed staff or qualified practitioner making the entry. A qualified practitioner shall countersign progress notes made by credentialed staff.

3410.18 Each MHRS provider shall develop and maintain sufficient written clinical documentation to support each therapy, service, activity, or session for which billing is made which, at a minimum, consists of:

(a) The specific service type rendered;

(b) The date, duration, and actual time, a.m. or p.m. (beginning and ending), during which the services were rendered;

(c) Name, title, and credentials of the person providing the services;

(d) The setting in which the services were rendered;

(e) Confirmation that the services delivered are contained in the consumer's IRP/IPC;

(f) A description of each encounter or service by a qualified practitioner or credentialed staff with the consumer which is sufficient to document that the service was provided in accordance with this Chapter; and

(g) Dated and authenticated entries, with their authors identified, which are legible and concise, including the printed name and the signature of the person rendering the service, diagnosis and clinical impression recorded in the terminology of the ICD-9 CM, the service provided and the signature of a qualified practitioner with authority to diagnose.

3410.19 Each MHRS provider shall ensure that all clinical records of consumers are completed promptly, filed, and retained in accordance with the MHRS provider's Clinical Records Policy.

3410.20 MHRS providers shall make MHRS available as follows:

MHRS	HOURS OF OPERATION	OTHER AVAILABILITY REQUIREMENTS
Diagnostic/Assessment	Six (6) days per week 9:00 am – 6:00 p.m., 3 days per week 9:00 am – 9:00 p.m., 2 days per week 4 hours on Saturday	CSA shall operate an on-call system for enrolled consumers, twenty-four (24) hours per day, seven (7) days per week.
Medication/Somatic Treatment	Six (6) days per week 9:00 am – 6:00 p.m., 3 days per week 9:00 am – 9:00 p.m., 2 days per week 4 hours on Saturday	CSA shall operate an on-call system for enrolled consumers, twenty-four (24) hours per day, seven (7) days per week.
Counseling and Psychotherapy	Six (6) days per week 9:00 am – 6:00 p.m., 3 days per week 9:00 am – 9:00 p.m., 2 days per week 4 hours on Saturday	CSA shall operate an on-call system for enrolled consumers, twenty-four (24) hours per day, seven (7) days per week.
Community Support	Twenty-four (24) hours per day, Seven (7) days per week	CSA shall operate an on-call system for enrolled consumers, twenty-four (24) hours per day, seven (7) days per week. Seventy-five percent (75%) or more of services shall be performed face-to-face. At least fifty percent (50%) of staff time shall be spent working outside the service site(s) with or on behalf of consumers.
Crisis/Emergency	Twenty-four (24) hours per day, Seven (7) days per week	Psychiatric consultation shall be available twenty-four (24) hours per day, seven (7) days per week
Rehabilitation	Thirty (30) hours per week, no less than six (6) hours per day	Consumers authorized and referred for service shall be admitted within seven (7) business days of the referral from the CSA.
Intensive Day Treatment	Seven (7) days per week, no less than five (5) hours per day	Programs serving adults shall offer a minimum of forty (40) hours of active programming per week. Programs serving children shall offer a minimum of thirty (30) hours of active programming per week. Consumers authorized and referred for Intensive Day Treatment shall be admitted within forty-eight (48) hours of referral by a CSA.
Community-Based Intervention	Twenty-four (24) hours per day, Seven (7) days per week	Consumers authorized and referred for CBI shall be admitted within forty-eight (48) hours of referral by a CSA. A CBI Team member shall respond to a call from family or a significant other, either by telephone or face-to-face contact within sixty (60) minutes of receiving the call.
Assertive Community Treatment	Twenty-four (24) hours per day, Seven (7) days per week, with emergency response coverage, to include psychiatric availability	Consumers authorized and referred for ACT shall be admitted within forty-eight (48) hours of referral by a CSA. At least sixty percent (60%) of ACT Services shall be provided in locations other than the office, according to consumer need, preference and clinical appropriateness. An ACT team member shall respond to a call from family or a significant other, either by telephone or face-to-face contact within sixty (60) minutes of receiving the call.

3410.21 Each MHRS provider shall establish and adhere to policies and procedures requiring the MHRS provider to make language interpreters available as needed for persons who do not use English as a first language or use a non-primary language for communication (Interpreter Policy). The Interpreter Policy shall:

(a) Prohibit a person acting as a language interpreter from simultaneously functioning as a qualified practitioner, in either individual treatment or treatment planning sessions; and

(b) Address the employment of qualified sign language interpreters.

3410.22 The Interpreter Policy shall allow staff and contractors who do not possess valid certification from the National Registry of Interpreters for the Deaf to be credentialed based on skills in mental health interpreting gained through supervised experience. For purposes of this rule, supervised experience shall include supervision by an interpreter certified by the National Registry of Interpreters for the Deaf and ongoing training in sign language interpreting, preferably related to mental health, and may include on-the-job learning prior to employment by the MHRS provider.

3410.23 Each MHRS provider shall utilize a TTY communications line (or an equivalent) to enhance the MHRS provider's ability to respond to service requests and needs of consumers and potential consumers. MHRS provider staff shall be trained in the use of such communication devices.

3410.24 Each MHRS provider shall establish and adhere to policies and procedures which govern the provision of services in natural settings (Natural Settings Policy). The Natural Settings Policy shall require the MHRS provider to document how it respects consumers' and families' right to privacy and confidentiality when services are provided in natural settings.

3410.25 Each MHRS provider shall establish and adhere to policies and procedures and an in-service training program for all staff regarding sensitivity to cultural issues, increasing cultural competence of all staff, and treating consumers with dignity and respect, addressing the following areas: beliefs, values, tradition, lifestyle practices, laws and regulations, formal and informal rules of behavior, spirituality, poverty, powerlessness, patienthood and disability (Cultural Competence Policy). Personnel files of all staff shall contain documentation that, at a minimum, eight (8) hours of training is completed annually, and that the training follows DMH's recommended curriculum for cultural sensitivity. Each MHRS provider shall ensure that services are delivered in a culturally sensitive manner.

3410.26 Each MHRS provider shall establish and adhere to anti-discrimination policies and procedures relative to hiring, promotion, and provision of services to consumers that comply with applicable federal and District laws and regulations (Anti-Discrimination Policy).

3410.27 Each MHRS provider shall establish and adhere to policies and procedures governing quality improvement (Quality Improvement Policy). The Quality Improvement Policy shall require the MHRS provider to adopt a written Quality Improvement (QI) plan describing the objectives and scope of its QI program and requiring MHRS provider staff, consumer, and family involvement in the QI program. DMH shall review and approve each MHRS provider's QI program. The QI program shall be operational and shall measure and ensure at least the following:

(a) Access and availability of services;

(b) Treatment and prevention of acute and chronic conditions;

(c) High volume services, high risk conditions and services, especially children and youth services;

(d) Coordination of care across behavioral health treatment and primary care treatment settings;

(e) Compliance with all MHRS certification standards;

(f) Adequacy, appropriateness and quality of care;

(g) Efficient utilization of resources; and

(h) Consumer and family satisfaction with services.

3410.28 Each MHRS provider shall comply with the following requirements for facilities management:

(a) Each MHRS provider's service site(s) shall be located and designed to provide adequate and appropriate facilities for private, confidential individual and group counseling sessions in consumer interview rooms.

(b) Each MHRS provider's service site(s) shall have appropriate space for group activities and educational programs.

(c) All areas of the MHRS provider's service site(s) shall be kept clean and safe, and shall be appropriately equipped and furnished for the services delivered.

(d) In-office waiting time shall be less than one (1) hour from the scheduled appointment time. Each MHRS provider shall demonstrate that it can document the time period for in-office waiting.

(e) Each MHRS provider shall comply with applicable provisions of the Americans with Disabilities Act in all business locations.

(f) Each MHRS provider's main service site shall be located within reasonable walking distance of public transportation.

(g) Each MHRS provider shall establish and adhere to a written evacuation plan to be used in fire, natural disaster, medical emergencies, bomb threats, terrorist attacks, violence in the work place, or other disaster for all service sites (Disaster Evacuation Plan).

(h) The Disaster Evacuation Plan shall require the MHRS provider:

(1) To conduct periodic disaster evacuation drills;

(2) Ensure that all evacuation routes are clearly marked by lighted exit signs; and

(3) Ensure that all staff participate in annual training about the Disaster Evacuation Plan and disaster response procedures.

(i) Each MHRS provider shall obtain a written certificate of compliance from the District of Columbia Department of Fire and Emergency Medical Services indicating that all applicable fire and safety code requirements have been satisfied.

(j) Each MHRS provider shall provide physical facilities for all service site(s) which are structurally sound and which meet all applicable federal and District laws and regulations for adequacy of construction, safety, sanitation and health.

(k) Each MHRS provider shall establish and adhere to policies and procedures governing infection control (Infection Control Policy). The Infection Control Policy shall comply with applicable federal and District laws and regulations, including, but not limited to the bloodborne pathogens standard set forth in 29 CFR § 1910.1030.

(l) Each MHRS provider shall establish and adhere to policies and procedures governing the purchasing, receipt, storage, distribution, return, and destruction of medication that include accountability for and security of medications located at any of its service site(s) (Medication Policy). The Medication Policy shall comply with applicable federal and District laws and regulations regarding the purchasing, receipt, storage, distribution, dispensing, return, and destruction of medications and require the MHRS provider to maintain all medications and prescription blanks in a secured and locked area.

3410.29 Each MHRS provider shall have established by-laws or other legal documentation regulating the conduct of its internal financial affairs. This documentation shall clearly identify the individual(s) that are legally responsible for making financial decisions for the MHRS provider and the scope of such decisionmaking authority. Each MHRS provider shall:

(a) Maintain an accounting system that conforms to generally acceptable accounting principles, provides for adequate internal controls, permits, the development of an annual budget, an audit of all income received and an audit of all expenditures disbursed by the MHRS provider in the provision of services;

(b) Have an internal process that allows for the development of interim and annual financial statements that compares actual income and expenditures

with budgeted amounts, accounts receivable, and accounts payable information; and

(c) Operate in accordance with an annual budget established by its governing authority.

3410.30 Each MHRS provider shall establish and adhere to policies and procedures governing the retention, maintenance, purging and destruction of its business records (Records Retention Policy). The Records Retention Policy shall:

(a) Comply with applicable federal and District laws and regulations;

(b) Require the MHRS provider to maintain all business records pertaining to costs, payments received and made, and services provided to consumers for a period of six (6) years or until all audits are completed, whichever is longer; and

(c) Require the MHRS provider to allow DMH, MAA, the District's Inspector General, the United States Department of Health and Human Services, the Comptroller General of the United States or any of their authorized representatives to review the MHRS provider's business records, including clinical and financial records.

3410.31 Each MHRS provider shall comply with the following requirements for maintaining certification, provider status, and contracts:

(a) Maintain proof of DMH certification;

(b) Maintain an active Medicaid provider status at all times if offering services to Medicaid-eligible consumers;

(c) Document referral arrangements in writing, using the DMH-approved affiliation agreement;

(d) Maintain copies of contracts with DMH, vendors, suppliers, and independent contractors; and

(e) Require that its subcontractors continuously comply with the provisions of the MHRS provider's Human Care Agreement with DMH.

3410.32 Each MHRS provider, at its expense, shall obtain the following minimum insurance coverage:

(a) Employer's liability coverage of at least one hundred thousand dollars ($100,000);

(b) Bodily injury liability insurance coverage written on the comprehensive form of policy of at least five hundred thousand dollars ($500,000) per occurrence;

(c) Workers' compensation insurance covering all of its employees as required by applicable District laws and regulations;

(d) Comprehensive automobile liability insurance applicable to owned, non-owned, and hired vehicles against liability for bodily injury and property damage, providing coverage of at least two hundred thousand dollars ($200,000) per person and five hundred thousand dollars ($500,000) per occurrence for bodily injury and twenty thousand dollars ($20,000) per occurrence for property damage;

(e) Medical malpractice insurance of not less than one million dollars ($1,000,000) for individual incidents and three million dollars ($3,000,000) in annual aggregate to cover all incidents of malpractice alleged to have occurred during the term of the MHRS provider's Human Care Agreement with DMH; and

(f) A "tail" for the medical malpractice insurance policy when: (a) the MHRS provider cancels or fails to renew the policy, or (b) the MHRS provider's Human Care Agreement with DMH expires, whichever occurs first.

3410.33 Each MHRS provider shall establish and adhere to policies and procedures governing billing and payment for MHRS (Billing and Payment Policy). The Billing and Payment Policy shall require the MHRS provider to have the necessary operational capacity to submit claims, document information on services provided, and track payments received. This operational capacity shall include the ability to:

(a) Verify eligibility for Medicaid and other third party payers;

(b) Document MHRS provided (by MHRS provider staff and subcontractors);

(c) Submit claims and documentation of MHRS to DMH on a timely basis; and

(d) Track payments for all MHRS provided enrolled or referred consumers.

3410.34 Each MHRS provider shall submit claims for MHRS provided to enrolled consumers to DMH within ninety (90) days of the date of service, or thirty (30) days after a secondary or third party payer has adjudicated a claim for this service. DMH shall not pay for a claim that is submitted more than one (1) year from the date of service, except when federal law or regulations would require such payment to be made.

3410.35 Each MHRS provider shall have an established sliding fee schedule covering each of the MHRS it provides. For services provided to Medicaid-eligible consumers, no additional charge shall be imposed for services beyond that paid by Medicaid.

3410.36 Each MHRS provider shall utilize and require its subcontractors to utilize payments from other public or private sources, including Medicare. Payment of DMH and federal funds to the MHRS provider shall be conditional upon the utilization of all benefits from other payment sources.

3410.37 Each MHRS provider shall operate according to all applicable federal and District laws and regulations relating to fraud and abuse in health care, the provision of mental health services, and the Medicaid program. An MHRS provider's failure to report potential or suspected fraud or abuse may result in sanctions, cancellation of contract, or exclusion from participation as an MHRS provider. Each MHRS provider shall:

(a) Cooperate and assist the District and any federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud and abuse; and

(b) Be responsible for promptly reporting suspected fraud and abuse to DMH, taking prompt corrective actions consistent with the terms of any contract or subcontract with DMH, and cooperating with MAA investigations.

3410.38 Each MHRS provider shall establish and adhere to a plan for ensuring compliance with applicable federal and District laws and regulations (Corporate Compliance Plan), approved by DMH. Each MHRS provider shall submit any updates or modifications to its Corporate Compliance Plan to DMH for prior review and approval. Each MHRS provider's Corporate Compliance Plan shall:

(a) Designate an officer or director with responsibility and authority to implement and oversee the operation of the Corporate Compliance Plan;

(b) Require that all officers, directors, managers, and employees know and understand its provisions;

(c) Include procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of MHRS;

(d) Include procedures for the confidential reporting of violations of the Corporate Compliance Plan to DMH, including procedures for the investigation and follow-up of any reported violations;

(e) Ensure that the identities of individuals reporting suspected violations of the Corporate Compliance Plan are protected and that individuals reporting suspected violations, fraud, or abuse are not retaliated against;

(f) Require that confirmed violations of the Corporate Compliance Plan be reported to DMH within twenty-four (24) hours of confirmation; and

(g) Require any confirmed or suspected fraud and abuse under state or federal law or regulation be reported to DMH.

3410.39 Each MHRS provider shall ensure that sufficient resources (e.g. personnel, hardware, software) are available to support the operations of computerized systems for collection, analysis, and reporting of information, along with claims submission.

3410.40 Each MHRS provider shall have the capability to interact with the DMH contract management system as required by DMH.

3410.41 Claims for MHRS shall be submitted using the format required by DMH.

3410.42 Each MHRS provider shall manage information in compliance with the confidentiality requirements contained in applicable federal and District laws and regulations.

3410.43 Each MHRS provider shall establish and adhere to a plan that contains policies and procedures for maintaining the security of data and information (Disaster Recovery Plan). Each MHRS provider's Disaster Recovery Plan shall also stipulate back-up and redundant systems and measures that are designed to prevent the loss of data and information and to enable the recovery of data and information lost due to disastrous events.

3411 CORE SERVICES AGENCY REQUIREMENTS

3411.1 Each CSA shall comply with the general certification standards described in §3410, the service specific certification standards applicable to core services and the certification standards set forth in this section, as well as the other certification standards in this Chapter.

3411.2 Each CSA shall serve as the clinical home for the consumers it enrolls. Each CSA shall employ clinical managers, except that a psychiatrist serving as a clinical manager may be under contract to the CSA. Each CSA shall be responsible for ensuring that IRPs/IPCs are developed and approved for its enrolled consumers, and shall provide clinical management for its enrolled consumers.

3411.3 Each CSA shall satisfy the following minimum staffing requirements:

(a) A Chief Executive Officer with professional qualifications and experience who meets the requirements established by the MHRS provider's governing authority. The Chief Executive Officer shall be charged with responsibility for day-to-day management of the CSA, and shall be a full-

time employee devoting at least twenty (20) hours a week to administrative and management functions for the CSA;

(b) A Medical Director who is a board-eligible psychiatrist, responsible for the quality of medical and psychiatric care provided by the MHRS provider. A child and youth-serving CSA may have a staff or consulting board-eligible child psychiatrist or a staff board-eligible psychiatrist with substantial child and adolescent experience as its Medical Director;

(c) A Clinical Director who is a qualified practitioner with an appropriate, relevant behavioral health advanced degree, with overall responsibility for oversight of the clinical program of the MHRS provider. The Clinical Director may also serve as the Medical Director if the Clinical Director is a board-eligible psychiatrist;

(d) A full-time Controller, Chief Financial Officer, or designated individual responsible for executing or overseeing the financial operations of the MHRS provider. The designated financial officer shall have a Bachelors Degree plus two (2) years of fiscal experience and may also oversee administrative operations and information services;

(e) A Quality Improvement Director responsible for developing and implementing the CSA's QI program; and

(f) A Medical Records Administrator, responsible for:

(1) Ongoing quality control of clinical documentation;

(2) Assuring that clinical records are maintained, completed, and preserved in accordance with the MHRS provider's Clinical Records Policy;

(3) Assuring that information on enrolled consumers is immediately retrievable; and

(4) Establishing a central records index for the MHRS provider.

3411.4 Each CSA shall comply with the following requirements regarding clinical operations:

(a) All consumers receiving treatment from or through a CSA shall choose a clinical manager from the CSA's staff.

(b) The clinical manager, along with the consumer and the approving practitioner, shall be responsible for the development of the consumer's IRP/IPC and coordinating the delivery of all MHRS received by the consumer.

(c) The clinical manager shall participate in the development of the IRP/IPC and shall periodically review its effectiveness with the consumer.

(d) The clinical manager shall be primarily responsible for assuring that the IRP assists the adult consumer in developing self-care skills and achieving recovery, and that the IPC assists the child or youth consumer and family to achieve age-appropriate growth and development.

(e) Each CSA shall establish and adhere to policies and procedures governing its relationship with subproviders and specialty providers (Affiliated Provider Policy). The Affiliated Provider Policy shall address, at a minimum, access to records, clinical responsibility, and dispute resolution.

(f) Each CSA shall establish and adhere to policies and procedures governing its relationship with subcontractors (Subcontractor Policy). The Subcontractor Policy shall address, at a minimum, access to records, clinical responsibility and supervision, legal liability, insurance and dispute resolution.

(g) Each CSA shall establish and adhere to policies and procedures governing the means by which family education and support will be offered and provided (Consumer and Family Education Policy). The Consumer and Family Education Policy shall require, at a minimum, the following:

(1) The CSA shall make family education and support available for all consumer families;

(2) Family education and support shall include general information about mental health and psychiatric illness;

(3) Specific information about a consumer's situation shall be provided with the permission of the consumer, or in the case of child, with the permission of the parent or guardian in accordance with the CSA's Release of Consumer Information Policy;

(4) The availability of appointments for family members to meet with staff and availability of family support and education groups to be scheduled at times convenient for the family; and

(5) In written materials and face-to-face contacts provide information about available and needed services, as well as how the consumer may access Crisis/Emergency services. The materials shall be written at the 4th grade reading level and shall be printed in English and either Spanish or the secondary language conducive to facilitating communication with the majority of the CSA's target population.

(b) All materials regarding the availability of certified MHRS providers shall be reviewed and approved by DMH.

3411.5 Each CSA shall comply with the following requirements regarding service accessibility:

(a) Each CSA shall operate an on-call system for its enrolled Consumers twenty-four (24) hours per day, seven (7) days per week, which is staffed by qualified practitioners to respond to urgent, emergency and routine situations (CSA On-Call System).

(b) Each CSA shall establish and adhere to policies and procedures governing the operation of its On-Call System (On-Call System Policy). The On-Call System Policy shall require the CSA to provide:

(1) Telephone access to a qualified practitioner for consumers and their significant others to resolve problems telephonically, where possible;

(2) Access to a qualified practitioner in order to provide pertinent face-to-face availability; and

(3) Linkage to Crisis/Emergency services, including crisis stabilization services and "next day" appointments to assist the consumer to address urgent problems during the next business day. The on-call qualified practitioner shall respond within two (2) hours to the consumer's request for service.

(c) Each CSA shall, at a minimum, offer the core services as required by §3414, §3415, §3416, §3417 and §3418 of these certification standards.

(d) Each CSA shall ensure that its business hours comply with the requirements of §3410.20 and facilitate each enrolled consumer's ability to choose an MHRS provider.

(e) Each potential consumer presenting with an urgent need shall be provided an appointment by a CSA with a qualified practitioner for a face-to-face intervention within the same day that the consumer presents for service.

(f) Each potential consumer presenting with a routine need shall be provided an intake appointment by a CSA for an intake appointment within seven (7) business days of presentation for service.

(g) Each CSA shall have policies and procedures for the provision of outreach services, including means by which these services and individuals will be targeted for such efforts (Outreach Policy). The Outreach Policy shall include procedures for protecting the safety of staff who engage in outreach activities.

3411.6 In addition to complying with the requirements set forth in §3410.27, each CSA shall have a QI program directed by a committee comprised of qualified practitioners and staff directly involved in the provision of services (QI Committee). The QI Committee shall:

(a) Be chaired by a qualified practitioner with direct access to the Chief Executive Officer;

(b) Include consumers and family members;

(c) Review unusual incidents, deaths, and other sentinel events, monitor and review utilization patterns, and track consumer complaints and grievances; and

(d) Conduct an annual evaluation of the QI program, periodically revise the QI program description, and develop the annual QI plan.

3411.7 Each CSA shall make a play area available for children in the waiting room area.

3411.8 Each CSA shall have a full-time Controller, Chief Financial Officer, or a designated individual who is responsible for executing or overseeing the financial operations of the CSA, as described in §3410.29, §3410.33, §3410.34, §3410.35, §3410.36, §3410.37, §3410.40, §3410.41 and §3411.9.

3411.9 Each CSA shall have an annual audit by a certified public accounting firm, and the resulting audit report shall be consistent with formats recommended by the American Institute of Public Accountants. A copy of the most recently certified annual audit report shall be submitted to DMH within one hundred-twenty (120) days after the close of the CSA's fiscal year.

3411.10 Each CSA shall enter into an affiliation agreement with its subproviders and all specialty providers that specifies the responsibilities of the parties.

3411.11 Each CSA shall be responsible for submitting IRP/IPC information to the DMH contract management system in order to register all medically necessary MHRS for its enrolled consumers and for updating and re-submitting the IRP/IPC for each of its enrolled consumers to the DMH contract management system at least every ninety (90) days and as necessary.

3411.12 Each CSA shall have the capability to submit timely and accurate claims, encounter data and other submissions as necessary directly to the DMH contract management system.

3411.13 DMH shall review and approve each CSA's Affiliated Provider Policy, Subcontractor Policy, Consumer and Family Education Policy, On-Call System Policy and Outreach Policy.

3412 SUBPROVIDER AND SPECIALTY PROVIDER REQUIREMENTS

3412.1 Each subprovider and specialty provider shall comply with the certification standards described in §3410, the service specific standards applicable to the MHRS offered by the subprovider or specialty provider and the certification standards described in this section, as well as the other certification standards in this Chapter.

3412.2 Subproviders shall provide one (1) or more of the core services only through an affiliation agreement with a CSA.

3412.3 Each subprovider shall establish and adhere to policies and procedures governing its relationship with a CSA which address access to records, clinical responsibility, legal liability, dispute resolution, and all other MHRS certification standards (CSA Affiliation Policy).

3412.4 Specialty providers shall provide one (1) or more of the specialty services only through a referral arrangement with a CSA which is documented in an affiliation agreement.

3412.5 Each specialty provider shall establish and adhere to policies and procedures governing its relationship with a CSA which address access to records, clinical responsibilities, legal liability, dispute resolution, and all other MHRS certification standards (CSA Referral Policy).

3412.6 Each subprovider and specialty provider shall satisfy the following minimum staffing requirements:

(a) A Chief Executive Officer or Program Director with professional qualifications and experience who shall meet requirements as established by the MHRS provider's governing authority and is responsible for day-to-day management of the MHRS provider;

(b) A Consulting Psychiatrist who is a board-eligible psychiatrist and advises the subprovider or specialty provider on the quality of medical and psychiatric care provided;

(c) Each child-serving subprovider and specialty provider shall demonstrate adequate child and adolescent psychiatric coverage by having a Consulting Psychiatrist who is either a board-eligible child psychiatrist or a board-eligible psychiatrist with substantial child and adolescent experience;

(d) A Clinical Director who is a qualified practitioner with overall responsibility for oversight of the clinical program of the subprovider or specialty provider;

(e) Each subprovider certified to provide either Diagnostic/ Assessment or Medication/Somatic Treatment shall demonstrate adequate oversight of quality of medical and psychiatric care by employing or contracting with a Medical Director or arranging for the Medical Director for the consumer's CSA to provide such oversight; and

(f) The required staff listed above shall be either employees of the subprovider or specialty provider or under contract to the subprovider or specialty provider for an amount of time sufficient to carry out the duties assigned.

3412.7 Each subprovider and specialty provider shall establish and adhere to policies and procedures governing its collaboration with a referring CSA in the development, implementation, evaluation, and revision of each consumer's IRP/IPC and ISSPs, as appropriate, that comply with DMH rules (Collaboration Policy). The Collaboration Policy shall:

(a) Be part of each subprovider and specialty provider's Treatment Planning Policy;

(b) Require subproviders and specialty providers to incorporate CSA-developed Diagnostic/Assessment material into the subprovider and specialty provider's treatment planning process; and

(c) Require subproviders and specialty providers to coordinate the consumer's treatment with the consumer's clinical manager.

3412.8 Each subprovider shall offer core services as required by §3410.20. At a minimum, the subprovider shall offer services during these hours at its primary location.

3412.9 At a minimum, each specialty provider shall offer access to specialty services as required by §3410.20.

3412.10 Each subprovider and specialty provider QI program shall be directed by a coordinator who is a qualified practitioner and who has direct access to the Chief Executive Officer (QI Coordinator). The QI Coordinator shall review unusual incidents, deaths, and other sentinel events, monitor and review utilization patterns, and track consumer complaints and grievances.

3412.11 Each subprovider and specialty provider with total annual revenues at or exceeding three hundred thousand dollars ($300,000) shall have an annual audit by a certified public accounting firm in accordance with generally accepted auditing standards. The resulting financial audit report shall be consistent with formats recommended by the American Institute of Public Accountants. Each subprovider and specialty provider shall submit a copy of the financial audit report to DMH ninety (90) days after the end of its fiscal year.

3412.12 Each subprovider and specialty provider with total annual revenues less than three hundred thousand dollars ($300,000) shall submit financial statements reviewed by an independent certified public accounting firm one hundred twenty (120) days after the end of its fiscal year.

3412.13 Each subprovider shall enter into an affiliation agreement with one (1) or more CSAs that specifies the terms of the arrangement between the parties.

3412.14 Each specialty provider shall enter into an affiliation agreement with all CSAs that specifies the terms of the arrangement between the parties.

3412.15 Each subprovider and specialty provider shall have the capability to submit timely and accurate claims, encounter data, and other submissions as necessary directly to the DMH contract management system.

3412.16 Each subprovider and specialty provider shall only provide those MHRS to consumers that are specified in the consumers' IRP/IPC as designated by the consumers' CSA.

3412.17 DMH shall review and approve the CSA Affiliation Policy, the CSA Referral Policy and the Collaboration Policy.

3413 QUALIFIED PRACTITIONERS AND CREDENTIALED STAFF

3413.1 Qualified practitioners are authorized to provide MHRS, as described below.

PROFESSIONAL TITLE	TYPES OF SERVICES AUTHORIZED TO PROVIDE	
Psychiatrist	Diagnostic/Assessment[1] Counseling and Psychotherapy Crisis/Emergency Intensive Day Treatment ACT	Medication/Somatic Treatment Community Support Rehabilitation CBI
Psychologist	Diagnostic/Assessment Community Support Rehabilitation CBI	Counseling and Psychotherapy Crisis/Emergency Intensive Day Treatment ACT
Independent Clinical Social Worker	Diagnostic/Assessment Community Support Rehabilitation CBI	Counseling and Psychotherapy[2] Crisis/Emergency Intensive Day Treatment ACT
Independent Social Worker	Diagnostic/Assessment (assessment only) Community Support Intensive Day Treatment ACT	Counseling and Psychotherapy Rehabilitation CBI
Advanced Practice Registered Nurse	Diagnostic/Assessment Counseling and Psychotherapy Crisis/Emergency Intensive Day Treatment ACT	Medication/Somatic Treatment Community Support Rehabilitation CBI
Registered Nurses	Diagnostic/Assessment (assessment only) Counseling and Psychotherapy Rehabilitation CBI	Medication/Somatic Treatment Community Support Intensive Day Treatment ACT
Licensed Professional Counselor providing mental health services	Diagnostic/Assessment (assessment only) Community Support Intensive Day Treatment ACT	Counseling and Psychotherapy Rehabilitation CBI
Addiction Counselors providing services to persons with co-occurring psychiatric and addictive disorders	Diagnostic/Assessment (assessment only) Community Support Intensive Day Treatment ACT	Counseling and Psychotherapy Rehabilitation CBI

[1] Only psychiatrists, psychologists, LICSW's and advance practice registered nurses may diagnose mental illness for purposes of receiving reimbursement for MHRS. Other qualified practitioners may provide assessment services only. Credentialed staff or other unlicensed staff may participate in selected components of the assessment, under the supervision of a qualified practitioner.

[2] Graduate social workers licensed in accordance with applicable District laws and regulations may provide Counseling and Psychotherapy under the supervision of an LICSW or an LISW.

3413.2 The staffing requirements for MHRS are described below.

MHRS	QUALIFIED PRACTITIONERS	QUALIFIED PRACTITIONERS AND CREDENTIALED STAFF WITH SUPERVISION
Diagnostic/ Assessment	• Psychiatrist • Psychologist • LICSW • Advance Practice Registered Nurse May diagnose and assess May serve as the approving practitioner	• Registered Nurse • LPC • LISW • Addiction Counselor • Credentialed Staff May provide assessment services only.
Medication/ Somatic Treatment	• Psychiatrist • Advance Practice Registered Nurse • Registered Nurse	None
Counseling and Psychotherapy	• Psychiatrist • Psychologist • LICSW • Advance Practice Registered Nurse • Registered Nurse • LISW • LPC • Addiction Counselor	• Licensed Graduate Social Worker may provide Counseling and Psychotherapy under the supervision of an LICSW or an LISW. • Credentialed Staff
Community Support	• Psychiatrist • Psychologist • LICSW • Advance Practice Registered Nurse • Registered Nurse • LPC • LISW • Addiction Counselor	Credentialed Staff
Crisis/ Emergency	• Psychiatrist • Psychologist • LICSW • Advance Practice Registered Nurse	• Registered Nurse • LPC • LISW • Addiction Counselor • Credentialed Staff
Rehabilitation	• Psychiatrist • Psychologist • LICSW • Advance Practice Registered Nurse • Registered Nurse • LPC • LISW • Addiction Counselor	Credentialed Staff
Intensive Day Treatment	• Psychiatrist • Psychologist • LICSW • Advance Practice Registered Nurse • Registered Nurse • LPC • LISW • Addiction Counselor	Credentialed Staff
CBI	• Psychiatrist • Psychologist • LICSW • Advance Practice Registered Nurse • Registered Nurse • LPC • LISW • Addiction Counselor	Credentialed Staff
ACT	• Psychiatrist • Registered Nurse • Addiction Counselor	Credentialed Staff

3414 COVERED MHRS

3414.1 The service specific standards described in this section apply to the individual MHRS offered by each MHRS provider.

3414.2 Covered core services include Diagnostic/Assessment, Medication/Somatic Treatment, Counseling and Psychotherapy, and Community Support.

3414.3 Covered specialty services include Crisis/Emergency, Rehabilitation, Intensive Day Treatment, CBI, and ACT.

3415 DIAGNOSTIC/ASSESSMENT

3415.1 A Diagnostic/Assessment is an intensive clinical and functional evaluation of a consumer's mental health condition by the Diagnostic/Assessment team that results in the issuance of a Diagnostic Assessment report with recommendations for service delivery that provides the basis for the development of an IRP/IPC. A psychiatrist shall supervise and coordinate all psychiatric and medical functions required by a consumer's Diagnostic/Assessment.

3415.2 A Diagnostic/Assessment shall:

(a) Determine whether the consumer is appropriate for and can benefit from MHRS based upon the consumer's diagnosis, presenting problems, and recovery goals; and

(b) Evaluate the consumer's level of readiness and motivation to engage in treatment.

3415.3 The Diagnostic/Assessment team shall include the following persons:

(a) At least two (2) qualified practitioners;

(b) One (1) of the members shall be a qualified practitioner whose professional licensure authorizes the qualified practitioner to diagnose mental illnesses;

(c) The approving practitioner who may also be the qualified practitioner authorized to diagnose mental illness; and

(d) A qualified practitioner who is knowledgeable about community resources, if one of the required Diagnostic/Assessment team members does not possess this knowledge.

3415.4 An initial Diagnostic/Assessment shall be performed by a Diagnostic/Assessment team for each consumer being considered for enrollment with a CSA.

3415.5 The Diagnostic/Assessment shall include the following elements:

(a) A chronological behavioral health history of the consumer's symptoms, treatment, treatment response, and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;

(b) For youth and adults, the chronological behavioral health history includes both psychiatric history and substance abuse history, treatment history for either or both diagnoses and the consumer's perception of the outcome;

(c) Biological, psychological, familial, social, and environmental dimensions and identified strengths and weaknesses in each area;

(d) A description of the presenting problem(s), including source of distress, precipitating events, associated problems or symptoms, and recent progression;

(e) Both a strengths summary and a problem summary which address the following:

(1) Risk of harm;

(2) Functional status, including relevant emotional and behavioral conditions or complications and addressing self-control, self-care, interpersonal abilities, coping, and independent living skills;

(3) Co-morbidity, including biomedical conditions and complications;

(4) Recovery environment, including supports and stressors; and

(5) Treatment and recovery history, including relapse potential;

(f) Diagnoses on all five (5) Axes of the DSM-IV;

(g) A review of the consumer's alcohol and substance abuse history and presenting problem(s), including an assessment of substances used and intensity of use, the likelihood and severity of withdrawal, and the medical and behavioral risk secondary to intoxication. This review either identifies or excludes substance abuse or dependence as a co-occurring treatment need;

(h) Assessment of the need for psychiatric hospitalization for consumers being referred to psychiatric inpatient services to assure that less restrictive alternatives are considered and used when appropriate;

(i) Evidence of an interdisciplinary team process; and

(j) Evidence of consumer participation including, families or guardians where required.

3415.6 The Diagnostic/Assessment may include psychological testing and, with prior authorization from DMH, neuropsychological assessments.

3415.7 Following the completion of the Diagnostic/Assessment, a summary of findings and recommendations for treatment shall be listed in a Diagnostic/Assessment report. A Diagnostic/Assessment report shall identify barriers to be addressed during treatment in order to reduce or eliminate identified deficits.

3415.8 A qualified practitioner shall complete the Diagnostic/Assessment report no later than ten (10) business days after the completion of the Diagnostic/Assessment by the Diagnostic/Assessment team. The qualified practitioner shall provide the Diagnostic/Assessment report to the approving practitioner, and the approving practitioner shall incorporate results of the Diagnostic/Assessment into the IRP/IPC.

3415.9 The approving practitioner shall convene the consumer, the consumer's family and significant others, if appropriate, and the consumer's clinical manager to review the Diagnostic/Assessment report and develop the IRP/IPC.

3416 MEDICATION/SOMATIC TREATMENT

3416.1 Medication/Somatic Treatment services are medical interventions including physical examinations; prescription, supervision or administration of medications; monitoring of diagnostic studies; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention.

3416.2 Medication/Somatic Treatment services include monitoring the side effects of medication and adverse reactions which a consumer may experience, and providing education and direction for symptom and medication self-management.

3416.3 Group Medication/Somatic Treatment services shall be therapeutic, educational and interactive with a strong emphasis on group member selection, facilitated therapeutic peer interaction and support as specified in the IRP/IPC.

3416.4 Each Medication/Somatic Treatment provider shall offer a comprehensive psychoeducational program for consumers and families, as appropriate, regarding the consumer's mental illness, emotional disturbance or behavior disorder, treatment goals, potential benefits and risk of treatment, self-monitoring aids, and consumer/family groups for education, support, and enhancement of the therapeutic alliance between the consumer and the MHRS provider.

3416.5 In conjunction with the development of the IRP/IPC, the ninety (90) day IRP/IPC review, the ninety (90) day ISSP review, and any time a consumer's medications are changed, consumers receiving Medication/Somatic Treatment shall participate in a psychoeducational session to discuss medication side effects, adverse reactions to medications, and medication self-monitoring and management.

3416.6 All consumers receiving Medication/Somatic Treatment services shall be evaluated on the Abnormal Involuntary Movement Scale (AIMS) annually, and the results of the AIMS testing shall be incorporated into the medication assessment and treatment planning process for each consumer receiving Medication/Somatic Treatment.

3417 COUNSELING AND PSYCHOTHERAPY

3417.1 Counseling and Psychotherapy services are individual, group or family face-to-face services for symptom and behavior management, development, restoration or enhancement of adaptive behaviors and skills, and enhancement or maintenance of daily living skills.

3417.2 Adaptive behaviors and skills and daily living skills include those skills necessary to access community resources and support systems, interpersonal skills, and restoration or enhancement of the family unit and support of the family.

3418 COMMUNITY SUPPORT

3418.1 Community Support services are rehabilitation and environmental supports considered essential to assist the consumer in achieving rehabilitation and recovery goals that focus on building and maintaining a therapeutic relationship with the consumer.

3418.2 Community Support services include a variety of interventions, such as:

(a) Participation in the development and implementation of a consumer's IRP/IPC and Community Support ISSP;

(b) Assistance and support for the consumer in crisis situations;

(c) Education, support and consultation to consumers' families and their support system, which is directed exclusively to the well-being and benefit of the consumer;

(d) Individual intervention for the development of interpersonal and community coping skills, including adapting to home, school, and work environments;

(e) Assisting the consumer in symptom self-monitoring and self-management for the identification and minimization of the negative effects of psychiatric symptoms which interfere with the consumer's daily living, financial management, personal development, or school or work performance;

(f) Assistance to the consumer in increasing social support skills and networks that ameliorate life stresses resulting from the consumer's disability and are necessary to enable and maintain the consumer's independent living;

(g) Developing strategies and supportive intervention for avoiding out-of-home placement for adults, children, and youth and building stronger family support skills and knowledge of the adult, child, or youth's strengths and limitations; and

(h) Developing relapse prevention strategies and plans.

3418.3 Community Support services may be provided by a team of staff that is responsible for an assigned group of consumers, or by staff who are individually responsible for assigned consumers.

3418.4 Community Support services provided to children and youth shall include coordination with family and significant others and with other systems of care, such as education managed health plans (including Medicaid managed care plans), juvenile justice, and children's protective services when appropriate to treatment and educational needs.

3418.5 Each Community Support provider shall have the ability to deliver services in natural settings.

3418.6 Each Community Support provider shall have policies and procedures included in its Service Specific Policies addressing the provision of Community Support (Community Support Organizational Plan) which address the following:

(a) Description of the particular rehabilitation, recovery, and case management models utilized, types of intervention practiced, and typical daily schedule for staff;

(b) Description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated;

(c) The use of level of functioning assessments to determine the number of consumers each staff can serve based on DMH guidelines; and

(d) Description of how the ISSP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.

3418.7 The Community Support provider shall maintain a staffing ratio of no less than one (1) staff person for every twenty (20) consumers for children and youth, and one (1) staff person for every forty (40) consumers for adults.

3418.8 Community Support services shall be delivered in accordance with the service accessibility requirements in §3410.20.

3419 **CRISIS/EMERGENCY**

3419.1 Crisis/Emergency is a face-to-face or telephone immediate response to an emergency situation involving a consumer with mental illness or emotional disturbance that is available twenty-four (24) hours per day, seven (7) days per week.

3419.2 Crisis/Emergency services are provided to consumers involved in an active crisis and consist of immediate response to evaluate and screen the presenting situation, assist in immediate crisis stabilization and resolution, and ensure the consumer's access to care at the appropriate level.

3419.3 Crisis/Emergency services may be delivered in natural settings, and the Crisis/Emergency provider shall adjust its staffing to meet the requirements for immediate response.

3419.4 Each Crisis/Emergency provider shall:

(a) Obtain consultation, locate other services and resources, and provide written and oral information to assist the consumer in obtaining follow-up services;

(b) Be a DMH-certified MHRS provider of Diagnostic/Assessment or have an agreement with a CSA or a CSA's affiliated subprovider to assure the provision of necessary hospital pre-admission screenings;

(c) Demonstrate the capacity to assure continuity of care for consumers by facilitating follow-up appointments and providing telephonic support until outpatient services occur; and

(d) Have an agreement with the DMH Consumer Enrollment and Referral System.

3419.5 Each site-based Crisis/Emergency provider shall have waiting, assessment, and treatment areas for children, youth, and families that are separate from the areas for adults.

3419.6 Each Crisis/Emergency provider shall establish and adhere to policies and procedures and staffing sufficient to ensure that all individuals seeking and in need of Crisis/Emergency services receive face-to-face services within one (1) hour of request or referral (Crisis/Emergency Staffing Policy). The Crisis/Emergency Staffing Policy shall:

(a) Require qualified practitioners to be available twenty-four (24) hours per day, seven (7) days per week for telephone, face-to-face and mobile interventions for individuals needing crisis services;

(b) Delineate the criteria upon which appropriate venue for service delivery is determined;

(c) Require that backup support for staff who need assistance during an intervention is always available;

(d) Require that all staff receive current training in persuasion, engagement, and de-escalation techniques for disruptive or aggressive acts, consumers, and situations; and

(e) Require all staff to hold current certification in cardiopulmonary resuscitation technique and first aid.

3420 **REHABILITATION**

3420.1 Rehabilitation is a facility-based, structured, clinical program intended to develop skills and foster social role integration through a range of social, educational, behavioral, and cognitive interventions. Rehabilitation services:

(a) Are curriculum-driven and psychoeducational and assist the consumer in the acquisition, retention, or restoration of independent and community living, socialization, and adaptive skills;

(b) Include cognitive-behavioral interventions and diagnostic, psychiatric, rehabilitative, psychosocial, counseling, and adjunctive treatment; and

(c) Are offered most often in group settings, and may be provided individually.

3420.2 Rehabilitation services shall:

(a) Be founded on the principles of consumer choice and the active involvement of each consumer in the consumer's rehabilitation;

(b) Provide both formal and informal structures through which consumers can influence and shape service development;

(c) Facilitate the development of a consumer's independent living and social skills, including the ability to make decisions regarding self care, management of illness, life work, and community participation;

(d) Promote the use of resources to integrate the consumer into the community; and

(e) Include education on self-management of symptoms, medications and side effects, the identification of rehabilitation preferences, the setting of rehabilitation goals, and skills teaching and development.

3420.3 Each consumer shall choose a full-time staff member to assist the consumer in assessing the consumer's needs and progress toward achievement of Rehabilitation Treatment Goals.

3420.4 Each Rehabilitation provider shall provide adequate space, equipment, and supplies to ensure that services can be provided effectively. Rehabilitation

program space and furnishings shall be separate and distinct from other services offered within the same service site(s).

3420.5 Each Rehabilitation provider shall have policies and procedures included in its Service Specific Policies addressing the provision of Rehabilitation (Rehabilitation Organizational Plan) which include:

(a) A description of the particular rehabilitation models utilized, types of intervention practiced, and typical daily curriculum and schedule;

(b) A description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated; and

(c) A description of how the ISSP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.

3420.6 Each Rehabilitation provider shall have a minimum of one (1) full-time equivalent staff for every ten (10) consumers, based on average daily attendance.

3420.7 At least one (1) qualified practitioner shall be present on site at all times.

3420.8 Each Rehabilitation provider shall have a clinical supervisor or director who is a qualified practitioner on site at least thirty (30) hours per week.

3421 **INTENSIVE DAY TREATMENT**

3421.1 Intensive Day Treatment is a facility-based, structured, intensive, and coordinated acute treatment program which serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care, rendered by an interdisciplinary team to provide stabilization of psychiatric impairments.

3421.2 Daily physician and nursing services are essential components of Intensive Day Treatment services.

3421.3 Intensive Day Treatment shall:

(a) Be time-limited and provided in an ambulatory setting to consumers who are not in danger but have behavioral health issues that are incapacitating and interfering with their ability to carry out daily activities;

(b) Be provided within a structured program of care which offers individualized, strengths-based, active, and timely treatment directed toward the alleviation of the impairment which caused the admission to Intensive Day Treatment;

(c) Be an active treatment program that consists of documented mental health interventions that address the individualized needs of the consumer as identified in the IRP/IPC;

(d) Consist of structured individual and group activities and therapies that are planned and goal-oriented and provided under active psychiatric supervision;

(e) Offer short-term day-programming consisting of therapeutically intensive, acute, and active treatment;

(f) Be services that closely resemble the intensity and comprehensiveness of inpatient services; and

(g) Include psychiatric, medical, nursing, social work, occupational therapy, Medication/Somatic Treatment, and psychology services focusing on timely crisis intervention and psychiatric stabilization so that consumers can return to their normal daily lives.

3421.4 Each consumer shall participate in at least five (5) hours of Intensive Day Treatment per day.

3421.5 Each consumer shall be directly evaluated by a qualified practitioner as part of the admissions process.

3421.6 Each consumer's care shall be supervised by a qualified practitioner who assumes primary responsibility for the consumer's assessment, treatment planning, and treatment services.

3421.7 Each consumer shall be assigned to a full-time staff member who assists the consumer and the consumer's family to assess the consumer's needs and progress toward achievement of Treatment Goals.

3421.8 An interdisciplinary treatment team shall meet within one (1) working day of the consumer's admission to develop an initial Intensive Day Treatment ISSP.

3421.9 Each Intensive Day Treatment ISSP shall be updated every three (3) days and shall be reviewed by the interdisciplinary treatment team on a weekly basis and upon termination of treatment.

3421.10 All Intensive Day Treatment services shall occur under the supervision of a psychiatrist. A psychiatrist shall assess each consumer on a daily basis.

3421.11 Each Intensive Day Treatment provider shall have policies and procedures included in its Service Specific Policies addressing the provision of Intensive Day Treatment (Intensive Day Treatment Organizational Plan) which include the following:

(a) A description of the particular treatment models utilized, types of intervention practiced, and typical daily curriculum and schedule;

(b) A description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated; and

(c) A description of how the ISSP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.

3421.12 The Intensive Day Treatment provider shall maintain a minimum staffing ratio of one (1) staff for every eight (8) consumers. The Intensive Day Treatment provider shall maintain a minimum staffing pattern sufficient to address consumer needs, including adequate physician, nursing, social work, therapy, and psychology services to assure the availability of intensive services.

3422 COMMUNITY-BASED INTERVENTION

3422.1 CBI services are time-limited, intensive, mental health intervention and wrap-around services delivered to children, youth, and adults and intended to prevent the utilization of an out-of-home therapeutic resource by the consumer.

3422.2 The basic goals of CBI services are to:

(a) Diffuse the current situation to reduce the likelihood of a recurrence, which, if not addressed, could result in the use of more intensive therapeutic interventions;

(b) Coordinate access to covered services; and

(c) Develop and improve the ability of parents, legal guardians, or significant others to care for the consumer with mental illness or emotional disturbance.

3422.3 CBI services shall be multi-faceted in nature and include:

(a) Situation management;

(b) Environmental assessment;

(c) Interventions to improve consumer and family interaction;

(d) Skills training;

(e) Self and family management; and

(f) Coordination and linkage with other covered services and supports in order to prevent the utilization of more restrictive residential treatment.

3422.4 CBI services shall be delivered primarily in natural settings and shall include in-home services. In-home services include consultation to the consumer, parents, or other caregivers regarding medications, behavior management skills, dealing with the responses of the consumer, other caregivers, and family members, and coordinating with other treatment providers, directed exclusively to the well-being and benefit of the consumer.

3422.5 CBI services shall be individually designed for each consumer and family to minimize intrusion and maximize independence.

3422.6 CBI services are normally more intensive at the beginning of treatment and decrease over time as the consumer or family's strengths and coping skills develop.

3422.7 CBI shall be provided through a team approach, utilizing flexible services, with the capacity to address concrete therapeutic and environmental issues in order to stabilize a situation as soon as possible.

3422.8 CBI services for children and youth shall always have a family-focus.

3422.9 Each CBI provider shall have policies and procedures included in its Service Specific Policies that address the provision of CBI (CBI Organizational Plan) which include the following:

(a) A description of the particular treatment models utilized, types of intervention practiced, and typical daily curriculum and schedule;

(b) A description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated; and

(c) A description of how the ISSP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.

3422.10 At a minimum, the CBI team shall include the following members:

(a) A full-time team leader or supervisor who is the clinical and administrative supervisor of the CBI team and who is a qualified practitioner;

(b) An addiction counselor working on a full-time basis and providing or accessing substance abuse services for CBI team consumers who functions as a primary practitioner on the CBI team for a caseload of consumers;

(c) A clinically trained generalist practitioner working on a full-time basis and providing individual and group supportive therapy to CBI team consumers

who functions as a primary practitioner on the CBI team for a caseload of consumers and is a qualified practitioner; and

(d) Recovery specialists carrying out rehabilitation and support functions who may be consumers in recovery that have been specially credentialed based on their psychiatric and life experiences. Recovery specialists are fully integrated CBI team members who provide consultation to the CBI team, highly individualized services in the community, and who promote consumer self-determination and decision making.

3422.11 The CBI team staff to family ratio shall not exceed four (4) families for the team at any given time.

3423 ASSERTIVE COMMUNITY TREATMENT

3423.1 ACT is an intensive, integrated, rehabilitative, crisis, treatment, and community support service provided to adult consumers with serious and persistent mental illness by an interdisciplinary team, with dedicated staff time and specific staff to consumer ratios.

3423.2 Service coverage by the ACT team is required twenty-four (24) hours per day, seven (7) days per week.

3423.3 The consumer's ACT team shall complete a comprehensive or supplemental assessment and develop a self care-oriented ISSP (if a current and effective one does not already exist).

3423.4 Services offered by the ACT team shall include:

(a) Medication prescription, administration, and monitoring;

(b) Crisis assessment and intervention;

(c) Symptom assessment, management, and individual supportive therapy;

(d) Substance abuse treatment for consumers with a co-occurring addictive disorder;

(e) Psychosocial rehabilitation and skill development;

(f) Interpersonal, social, and interpersonal skill training; and

(g) Education, support, and consultation to consumers' families and their support system which is directed exclusively to the well-being and benefit of the consumer.

3423.5 ACT services shall include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings by the consumer's ACT team.

3423.6 The ACT team provides community support services that are interwoven with treatment and rehabilitative services and regularly scheduled team meetings. ACT team meetings shall be held a minimum of three (3) times a week.

3423.7 ACT services and interventions shall be highly individualized and tailored to the needs and preferences of the consumer, with the goal of maximizing independence and supporting recovery.

3423.8 Each ACT provider shall have policies and procedures included in its Service Specific Policies that address the provision of ACT (ACT Organizational Plan) which include the following:

(a) A description of the particular treatment models utilized, types of intervention practice, and typical daily curriculum and schedule;

(b) A description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated; and

(c) A description of how the ISSP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.

3423.9 At a minimum, the ACT team shall include the following members:

(a) A full-time team leader or supervisor who is the clinical and administrative supervisor of the ACT team and who is a qualified practitioner;

(b) A psychiatrist working on a full-time or part-time basis for a minimum of four (4) hours per week per twenty (20) consumers that provides clinical and crisis services to all consumers served by the ACT team, works with the ACT team leader to monitor each consumer's clinical status and response to treatment, and directs psychopharmacologic and medical treatment;

(c) A registered nurse working on a full-time basis and providing nursing services for all ACT team consumers who works with the ACT team to monitor each consumer's clinical status and response to treatment and functions as a primary practitioner on the ACT team for a caseload of consumers;

(d) An addiction counselor working on a full-time basis and providing or accessing substance abuse services for ACT team consumers who functions as a primary practitioner on the ACT team for a caseload of consumers;

(e) A clinically trained generalist practitioner working on a full-time basis and providing individual and group supportive therapy to ACT team consumers who functions as a primary practitioner on the ACT team for a caseload of consumers and is a qualified practitioner; and

(f) Recovery specialists carrying out rehabilitation and support functions who may be consumers in recovery that have been specially credentialed based on their psychiatric and life experiences. Recovery specialists are fully integrated ACT team members who provide consultation to the ACT team, highly individualized services in the community, and who promote consumer self-determination and decision making.

3423.10 The ACT team shall maintain a minimum consumer-to-staff ratio of no more than twelve (12) consumers per staff person, and such ratio shall take into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

3424 REIMBURSABLE SERVICES

3424.1 Reimbursement for the provision of MHRS shall be on a per unit basis as indicated in §3424.4.

3424.2 Each covered service shall have a unique billing code as established by DMH.

3424.3 Units of service reported for part of an hour shall be rounded to the nearest fifteen minute unit.

3424.4 Reimbursement shall be limited as follows:

MHRS	LIMITATIONS AND SERVICE SETTING	BILLABLE UNIT OF SERVICE
Diagnostic/ Assessment	• One (1) every six (6) months • Additional units allowable for periodic assessment and pre-hospitalization screening • Neuropsychological assessment allowable with prior authorization by DMH • Shall not be billed the same day as ACT • Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less	An assessment, which is at least three (3) hours in duration
Medication/ Somatic Treatment	• No annual limit • Shall not be billed the same day as ACT • Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less	One (1) hour (or part thereof)
Counseling and Psychotherapy	• Forty (40) units per year • Additional units allowable with prior authorization by DMH • Shall not be billed the same day as Rehabilitation, Intensive Day Treatment, CBI or ACT • Shall be rendered face-to-face, when consumer is present, unless there is adequate documentation to justify why the consumer was not present during the session • Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less	One (1) hour (or part thereof)
Community Support	• No annual limits • Shall not be billed on the same day as ACT • Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less	One (1) hour (or part thereof)
Crisis/ Emergency	• No annual limits • Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less	One (1) hour (or part thereof)
Rehabilitation	• Ninety (90) days within a twelve (12) month period • Additional units allowable with prior authorization by DMH • Shall not be billed on the same day as Counseling and Psychotherapy or Assertive Community Treatment • Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less	One (1) day (which shall consist of at least three (3) hours)
Intensive Day Treatment	• Seven (7) days • Additional units allowable after seven (7) days or for the second and any additional episodes of care within a twelve (12) month period with prior authorization by DMH • Shall not be billed on the same day as any other MHRS, except for Crisis/Emergency, Community Support and CBI. • Up to three (3) hours of Diagnostic/Assessment may be billed during each episode of Intensive Day Treatment • Provided only in a community-based MHRS provider -- Intensive Day Treatment Facility	One (1) day (which shall consist of at least five (5) hours)
CBI	• Prior authorization from DMH required for enrollment • Shall not be billed on the same day as Assertive Community Treatment, Counseling and Psychotherapy or Intensive Day Treatment • Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less	One (1) hour (or part thereof)
Assertive Community Treatment	• Prior authorization from DMH required for enrollment • Shall not be billed on the same day as any other MHRS, except for Crisis/Emergency with retrospective authorization	One (1)hour (or part thereof)

3425 NON-REIMBURSABLE SERVICES

3425.1 Services not covered as MHRS include, but are not limited to:

(a) Room and board residential costs;

(b) Inpatient hospital services;

(c) Transportation services;

(d) Vocational services;

(e) Socialization services;

(f) Prevention services;

(g) Services which are not medically necessary;

(h) Services which are not provided and documented in accordance with these certification standards;

(i) Services which are not mental health services; and

(j) Services furnished to persons other than the consumer when those services are not directed primarily to the wellbeing of the consumer.

3499 DEFINITIONS

3499.1 The following terms have the meaning ascribed in this section:

"Addiction counselor" - a person who provides addiction counseling services to persons with co-occurring psychiatric and addictive disorders and is licensed or certified in accordance with applicable District laws and regulations. An addiction counselor is a qualified practitioner.

"Advance Practice Registered Nurse" or "APRN" - a person licensed as an advance practice registered nurse in accordance with applicable District laws and regulations, with psychiatry as an area of practice and working in a collaborative protocol with a psychiatrist. An Advance Practice Registered Nurse is a qualified practitioner.

"Affiliation agreement" - an agreement in the form approved by DMH by and between a CSA and a specialty provider or subprovider that describes how they will work together to benefit consumers.

"Approving practitioner" - the qualified practitioner responsible for overseeing the development of and approval of the Individual Recovery Plan or Individual

Plan of Care ("IRP/IPC"). The approving practitioner serves on the Diagnostic/Assessment team and may also serve as the clinical manager.

"Assertive Community Treatment" or "ACT" - intensive, integrated rehabilitative, crisis, treatment, and community support provided to adult consumers with serious and persistent mental illness by an interdisciplinary team. ACT is a specialty service.

"Assertive Community Treatment team" or "ACT team" - the mobile inter-disciplinary team of qualified practitioners and other staff involved in providing ACT to a consumer.

"CBI team" – The interdisciplinary team of qualified practitioners and other staff involved in providing CBI to a consumer.

"CMS" - Centers for Medicare and Medicaid services, formerly known as the Health Care Financing Agency.

"Certification" - the written authorization from DMH rendering an entity eligible to provide MHRS. DMH grants certification to community-based organizations that submit an approved certification application and satisfy the certification standards.

"Certification application" - the application and supporting materials prepared and submitted to DMH by a community-based organization requesting certification to provide MHRS.

"Certification standards" - the minimum requirements established by DMH in this Chapter that an MHRS provider shall satisfy to obtain and maintain certification to provide MHRS and receive reimbursement from DMH for MHRS.

"Clinical manager" - the qualified practitioner chosen by the consumer to coordinate service delivery. The clinical manager shall participate in the development and review of the consumer's IRP/IPC, along with the approving practitioner. The clinical manager may also serve as the approving practitioner. The clinical manager shall be employed by the CSA, except that a psychiatrist serving as a clinical manager may be under contract to the CSA.

"Community-Based Intervention" or "CBI" - time-limited, intensive, mental health interventions and wrap-around services delivered to children, youth, or adults and intended to prevent utilization of an out-of-home therapeutic resource by the consumer. CBI is a specialty service.

"Community Support" - rehabilitation and environmental support considered essential to assist a consumer in achieving rehabilitation and recovery goals. Community Support is a core service.

"Consumer" – a person eligible to receive MHRS as defined in the District of Columbia Department of Mental Health Establishment Congressional Review Emergency Amendment Act of 2001, effective July 23, 2001 (D.C. Act 14-101).

"Core services" includes the following four categories of MHRS: Diagnostic/ Assessment, Medication/Somatic Treatment, Counseling and Psychotherapy, and Community Support.

"Core Services Agency" or "CSA" - a DMH-certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a subprovider or subcontractor. A CSA may provide specialty services directly if certified by DMH as a specialty provider. However, a CSA shall also offer specialty services via an affiliation agreement with all specialty providers.

"Corporate Compliance Plan" - a written plan developed by each MHRS provider to ensure that the MHRS provider operates in compliance with all applicable federal and District laws and regulations.

"Counseling and Psychotherapy" - individual, group, or family face-to-face services for symptom and behavior management, development, restoration, or enhancement of adaptive behaviors and skills, and enhancement or maintenance of daily living skills. Counseling and Psychotherapy is a core service.

"Credentialed staff" - unlicensed staff or staff who are not qualified practitioners that are credentialed by the MHRS provider to perform certain MHRS or components of MHRS under the clinical supervision of a qualified practitioner.

"Crisis/Emergency" - face-to-face or telephone immediate response to an emergency situation experienced by a consumer or significant others. Crisis/Emergency is a specialty service.

"Cultural competence" - means the ability of a MHRS provider to deliver mental health services and mental health supports in a manner that effectively responds to the languages, values, and practices present in the various cultures of the MHRS provider's consumers.

"Diagnostic/Assessment" - intensive clinical and functional evaluation of a consumer's mental health condition that results in the issuance of a Diagnostic/Assessment report with recommendations for service delivery and may provide the basis for the development of the IRP/IPC. Diagnostic/Assessment is a core service.

"Diagnostic/Assessment report" - the report prepared by the Diagnostic/ Assessment team that summarizes the results of the Diagnostic/Assessment service and includes recommendations for service delivery. The Diagnostic/Assessment report is used to initiate the IRP/IPC and, if necessary, the ISSP.

"Diagnostic/Assessment team" - at least two (2) qualified practitioners working together to complete the Diagnostic/Assessment and issue the Diagnostic/Assessment report.

"Director" - the director of DMH.

"Disaster Recovery Plan" - the policies and procedures developed by each MHRS provider to ensure that computerized data is properly maintained and can be retrieved in the event of a disaster.

"District of Columbia" or "District" – the government of the District of Columbia.

"District of Columbia State Medicaid Plan" - the plan approved by CMS that is developed and administered by MAA, pursuant to Section 1(b) of An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program and for other purposes and Title XIX of the Social Security Act as added July 30, 1965 (79 Stat. 343; 42 U.S.C. §1396a et seq.), as amended. The program operated in accordance with the District of Columbia State Medicaid Plan is referred to as the "Medicaid" or "Medical Assistance" program.

"DMH" - the Department of Mental Health, the successor in interest to the District of Columbia Commission on Mental Health Services.

"DMH Consumer Enrollment and Referral System" - the system developed and administered by DMH to enroll eligible consumers into the MHRS system.

"DSM IV" - the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

"Emergency" - a situation in which a consumer is experiencing a mental health crisis and the immediate provision of mental health treatment is, in the written judgment of the consumer's attending physician, necessary to prevent serious injury to the consumer or others.

"Governing authority" - the designated individuals or governing body legally responsible for conducting the affairs of the MHRS provider.

"Grievance" - a description by any individual of his or her dissatisfaction with an MHRS provider, including the denial or abuse of any consumer right or protection provided by applicable federal and District laws and regulations.

"Human Care Agreement" - the written agreement entered into by the DMH-certified MHRS provider and DMH which describes how the parties will work together.

"ICD-9CM" - the most recent version of the International Classification of Diseases Code Manual.

"Independent clinical social worker" or "LICSW" - a person licensed as an independent clinical social worker in accordance with applicable District laws and regulations. An LICSW is a qualified practitioner.

"Individualized Plan of Care" or "IPC" - the individualized plan of care for children and youth, which is the result of the Diagnostic/Assessment. The IPC is maintained by the consumer's CSA. The IPC includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IPC is based on the consumer's identified needs as reflected by the Diagnostic/Assessment, the consumer's expressed needs, and referral information. The IPC shall include a statement of the specific, individualized objectives of each intervention, a description of the interventions, and specify the frequency, duration, and scope of each intervention activity. The IPC also includes the ISSP developed by subproviders and specialty providers involved in providing services to the consumer. The IPC is the authorization of treatment, based on certification that the MHRS are medically necessary by the approving practitioner.

"Individualized Recovery Plan" or "IRP" - an individualized recovery plan for adult consumers, which is the result of the Diagnostic/Assessment. The IRP is maintained by the consumer's CSA. The IRP includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IRP is based on the consumer's identified needs as reflected by the Diagnostic/Assessment, the consumer's expressed needs, and referral information. The IRP shall include a statement of the specific, individualized objectives of each intervention, a description of the interventions, and specify the frequency, duration, and scope of each intervention activity. The IRP also includes the ISSP developed by subproviders and Specialty providers involved in providing services to the consumer. The IRP is the authorization of treatment, based upon certification that MHRS are medically necessary by an approving practitioner.

"Individualized Service Specific Plan" or "ISSP" - the individualized service specific plan developed by an MHRS provider providing Medication/Somatic Treatment, Counseling and Psychotherapy, Community Support, Rehabilitation, Intensive Day Treatment, CBI, or ACT. The ISSP shall be consistent with the IRP/IPC and specify the qualified practitioner designated to deliver the MHRS, and the frequency, duration, and scope of the MHRS.

"Inpatient mental health service" - residence and treatment provided in a psychiatric hospital or unit licensed or operated by the District of Columbia.

"Intensive Day Treatment" - a facility-based, structured, intensive, and coordinated acute treatment program which serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care. Its duration is time-limited. Intensive Day Treatment is provided in an ambulatory setting. Intensive Day Treatment is a specialty service.

"Licensed independent social worker" or "LISW" - a person licensed as a licensed independent social worker in accordance with applicable District laws and regulations. An LISW is a qualified practitioner.

"Licensed professional counselor" or "LPC" - a professional counselor licensed in accordance with applicable District laws and regulations. An LPC is a qualified practitioner.

"MAA" - the Department of Health, Medical Assistance Administration.

"MAA/DMH Interagency Agreement" - a written agreement entered into by MAA and DMH which describes how MAA and DMH will handle the operation and administration of the MHRS program.

"Medicaid or Medical Assistance" - the program described in the District of Columbia State Medicaid Plan, approved by CMS, and administered by MAA pursuant to Section 1(b) of An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program and for other purposes and Title XIX of the Social Security Act, as amended July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396a et seq.).

"Medically necessary" - those services contained in an approved IRP/IPC reasonably calculated to prevent the worsening of, alleviate, correct, cure, or ameliorate an identified mental health condition that endangers life, causes suffering or pain, causes physical deformity or bodily malfunction, threatens to cause or aggravate a disability, or results in an illness or infirmity. For children through age twenty (20), services reasonably calculated to promote the development or maintenance of age-appropriate functioning are also considered medically necessary.

"Medication/Somatic Treatment" - medical interventions, including physical examinations, prescription, supervision or administration of medications, monitoring of diagnostic studies, and medical interventions needed for effective mental health treatment provided as either an individual or group intervention. Medication/Somatic Treatment is a core service.

"Mental Health Rehabilitation Services" or "MHRS" - mental health rehabilitative or palliative services provided by a DMH-certified community mental health provider to consumers in accordance with the District of Columbia State Medicaid Plan, the MAA/DMH Interagency Agreement, and this chapter.

"Mental illness" - a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

"MHRS provider" - an organization certified by DMH to provide MHRS. MHRS provider includes CSAs, subproviders, and specialty providers.

"Natural settings" - the consumer's residence, workplace, or other locations in the community the consumer frequents, such as the consumer's home, school, workplace, community centers, homeless shelters, street locations, or other public facilities. Natural settings do not include inpatient hospitals or community residential facilities.

"Neglect" - any act or omission by a MHRS provider which causes or is likely to cause or contribute to, or which caused or is likely to have caused or contributed to, injury or death of a consumer.

"Policy" - a written statement developed by an MHRS provider that gives specific direction regarding how the MHRS provider shall operate administratively and programmatically.

"Procedure" - a written set of instructions describing the step-by-step actions to be taken by MHRS provider staff in implementing a policy of the MHRS provider.

"Psychiatrist" - a physician licensed in accordance with applicable District laws and regulations who, at a minimum, is a board-eligible psychiatrist. A Psychiatrist is a qualified practitioner.

"Psychologist" - a person licensed to practice psychology in accordance with applicable District laws and regulations. A Psychologist is a qualified practitioner.

"Qualified practitioner" - (i) a board-eligible psychiatrist; (ii) a psychologist; (iii) an independent clinical social worker; (iv) an advance practice registered nurse; (v) a registered nurse; (vi) a licensed professional counselor; (vii) an independent social worker; and (viii) an addiction counselor.

"Referral" - a recommendation to seek or request services or evaluation between a CSA and a subprovider or specialty provider in order to assess or meet the needs of consumers.

"Registered nurse" or "RN" - a person licensed as a registered nurse in accordance with applicable District laws and regulations. An RN is a qualified practitioner.

"Rehabilitation" - a facility-based, structured, clinical program intended to develop skills and foster social role integration through a range of social, educational, behavioral, and cognitive interventions. Rehabilitation services are curriculum-driven and psychoeducational and assist the consumer in the acquisition, retention, or restoration of community living, socialization, and adaptive skills. Rehabilitation services include cognitive-behavioral interventions and diagnostic, psychiatric, rehabilitative, psychosocial, counseling, and adjunctive treatment. Rehabilitation services are offered most often in group settings. Rehabilitation is a specialty service.

"Service specific standards" - the certification standards described in §3414, §3415, §3416, §3417, §3418, §3419, §3420, §3421, §3422 and §3423, which set forth the specific requirements applicable to each MHRS.

"Specialty provider" - a community-based organization MHRS provider certified by DMH to provide specialty services either directly or through contract. Each specialty provider shall enter into an affiliation agreement with each DMH-certified CSA.

"Specialty services" - ACT, CBI, Crisis Intervention/Emergency, Intensive Day Treatment, and Rehabilitation.

"Subcontractor" - a licensed independent practitioner qualified to provide mental health services in the District. A subcontractor may provide one or more core service(s) under contract with a CSA. A subcontractor may also provide specialty service(s) under contract with a specialty provider.

"Subcontractor Agreement" - an agreement by and between an MHRS provider and a subcontractor that describes how they will work together to benefit consumers in the form approved by DMH.

"Subprovider" - a community-based organization certified by DMH to provide one or more core service(s) through an affiliation agreement with a CSA.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

Community Services Agency, 35 K Street, NE, Washington, DC, 20002, (202) 442-4100

VIA FACSIMILE

March 19, 2002

Dear Labor Leadership Presidents/Representatives:

This is in follow-up to the Consultation Meeting held on Thursday, March 14, 2002 regarding the required working condition changes for the Community Services Agency (CSA). As I have mentioned in the December and January monthly Labor Leadership meetings, the changes are being necessitated by the Mental Health Rehabilitation Service standards, which CSA must operate under.

Your comments and concerns voiced during the Consultation Meeting have been taken under advisement. If you have any further concerns and would like to have them addressed, kindly request. Your request must be in writing and it must identify the impact the changes will have on your members, along with suggested resolutions to each impacted area identified. In order to address the potential impact on your members, you must submit the above requested information to me no later than Friday, March 22, 2002.

As indicated during our consultation, I have enclosed a sample copy of the letter we will begin sending to employees to notify them of the necessary changes.

If you have any questions or concerns, kindly direct them to Brendolyn McCarty-Jones at (202) 442-4102.

Sincerely,

Deborah A. Hobbs for

Juanita Price
Chief Executive Officer
Community Services Agency

Enclosure

cc: Martha Knisley
Ivy McKinley

Exhibit #3